Consent to medical treatment: To what extent does the post 1994 South African legal framework on consent protect patients: A critical review.

By

NOMPUMELELO BANGO-RILI

This research project is submitted in partial fulfilment of the regulations for LLM degree at the University of KwaZulu-Natal. College of Law and Management Studies, School of Law.

SUPERVISOR: PROFFESSOR ANN STRODE

August 2021

STATEMENT

Student Number: 212531105

I, NOMPUMELELO BANGO-RILI, declare that:

"CONSENT TO MEDICAL TREATMENT: TO WHAT EXTENT DOES THE POST 1994 SOUTH AFRICAN LEGAL FRAMEWORK ON CONSENT PROTECT PATIENTS? A CRITICAL REVIEW"

Is my own work and that all sources that I have used or quoted have been indicated and acknowledged by means of complete references.

This project is an original piece of work which is made available for photocopying and for inter-library loan.

25 August 2021

______________________________ ____________________

NOMPUMELELO BANGO-RILI **DATE**

ACKNOWLEDGMENTS

"Education is the great engine of personal development. It is through education that a daughter of a peasant can become a doctor, that the son of a mine worker can become the head of a mine that a child of farm workers can become a president of a great nation. It is what we make out of what we have, not what we are given, that separates one person from another

Nelson Mandela

Firstly I would like to acknowledge my supervisor Professor Ann Strode for her tireless work in assisting me to complete this dissertation and for believing in me. For critiquing my work with respect and encouragement; making me want to do better and better.

I would also like to acknowledge my husband Mbongeni Rili for his financial and emotional support during my journey into finishing this project. It has been hard, but he was there through it all; the midnight researches I did, putting it into writing throughout the night on some occasions. His endless support has been my anchor, and for that I acknowledge him.

My kids, Iluthando, Thando and Intando, for giving me the space I needed to finish this work, much love.

TABLE OF CONTENTS

STATEMENT 2

ACKNOWLEDGEMENTS 3

CHAPTER 1…………………………………………………………………………………...6

BACKGROUND…………..………………………………………………………………..6

Literature Review …………………………………………………………………...........................8

Aims, Objectives and Research questions………………………………………………………13

Research Methodology…………………………………………………………………………..13

Outline of Chapters ……………………………………………………………………………...14

CHAPTER 2……………………………………………………………………………………15

THE LEGAL FRAMEWORK FOR CONSENT TO MEDICAL TREATMENT………………15

The Constitution……………………………………………………………………….........15

Right to Dignity………………………………………………………………………………….16

Right to bodily integrity……………………………………………………………….........17

Children's rights…………………………………………………………………………………20

Limiting the rights in the Constitution…………………………………………………………...21

The National Health Act…………………………………………………………………....23

Consent to medical treatment……………………………………………………………………24

Medical treatment without consent………………………………………………………………26

The Children's Act………………………………………………………………………………28

Overview of consent to medical treatment by children………………………………………….28

Independent consent by children to medical treatment, surgery and procedures …………………….29

Consent by children under the age of 12…………………………………………………………31

The best interests of the child……………………………………………………………………31

Consent by children to surgical operations ……………………………………………………...32

Refusal of treatment by children………………………………………………. ………………..33

Parents refusing medical treatment for children……………………………………………………33

The Mental Health Care Act………………………………………………………………………..35

Determining capacity to consent to medical treatment by psychiatric patients………………………36

Capacity to consent by psychiatric patients in light of the National Health Act……………………...37

Sterilization Act……………………………………………………………………….................38

The Choice of Termination of Pregnancy Act………………………………………………..............38

Common Law……………………………………………………………………………………39

CHAPTER 3……………………………………………………………………………........44

Analysis and Discussion………………………………………………………………...........44

Strengths of legislation dealing with consent to medical treatment…………………………………..47

Complexities……………………………………………………………………………………..48

Weaknesses………………………………………………………………………………………51

CHAPTER 4…………………………………………………………………………………….54

Conclusions and Recommendations……………………………………………………………..54

Recommendations………………………………………………………………………………..57

BIBLIOGRAPHY……………………………………………………………………........59

Table of Cases……………………………………………………………………………………63

Table of Statutes …….…………………………………………………………………………..64

Books…..………………………………………………………………………………………...65

Dissertations……..………………………………………………………………………………65

CONSENT TO MEDICAL TREATMENT: TO WHAT EXTENT DOES THE POST 1994 SOUTH AFRICAN LEGAL FRAMEWORK ON CONSENT PROTECT PATIENTS? A CRITICAL REVIEW

CHAPTER ONE: INTRODUCTION

1.1 BACKGROUND

It has been firmly established in South African law that informed consent prior to the commencement of any form of medical procedure is required by the patient, or proxy decision maker; this principle has been established in South African law by two seminal cases **Stoffberg v Elliot**[1] and **Castell v De Greef**. [2] This means ethically and legally patient autonomy means that the decisions of the patients must be (a) informed, (b) independent, (b) voluntary and (c) respected.[3] The amount of information that must be given to each patient will vary according to factors such as the nature of the condition, the complexity of the treatment, the risk associated with the treatment or procedure, and the patient's own wishes.[4] Informed consent to medical treatment means that sufficient information must be provided for the patient to enable them to make an informed decision; the patient must also understand the information, the implications and all consequences of acting on such information.[5] Operationally informed consent requires, (other than in an emergency) a doctor / healthcare worker to obtain a patient's agreement to any course of investigation, treatment and research.[6] Doctors are required to tell the patient anything that would substantially affect their decision.[7]

Such information typically includes the nature, and purpose of the treatment, the risks and consequences and alternative courses of treatment.[8] The rule established in **Castell v De Greef**

---

[1] 1923 CPD 148.
[2] C. Van de Westhuizen, 'Medical Treatment v Surgery: where does medical treatment ends and surgery begin in terms of section 129 of the Children's Act?'(2018) Obiter Vol 39 (3): 791-802 at page 791.
[3] D. McQuoid –Mason, 'Michael Jackson and the limits of patient autonomy' (2012) *South African Journal of Bioethics and Law* Vol 5 (1): 11-14 at page 11.
[4] Health Professions Council of South Africa. *'Guidelines for good practice in the health care professions*. Seeking patient's informed consent: the ethical consideration' (2016) Booklet 4 pages 86-103 at page 90.
[5] *Ibid.*
[6] K.D Bolton 'Informed Consent' (2012) *South African Orthopaedic Journal* Vol.11 (3): 108-111 at page 108.
[7] *Ibid* at page 108
[8] *Ibid* at page 108

was that in South Africa, where the question of consent to medical treatment is seen as falling under the defence of *volenti non fit injuria*; a doctor's duty to disclose material risk must be seen in a contractual setting of unimpeachable consent to operation and its sequelae.[9] Ackerman in the Castell case went further to state, at page 427:

> "I therefore conclude that, in our law, for a patient's consent to constitute justification that excludes the wrongfulness of medical treatment and its consequences, the doctor is obliged to warn a patient so consenting of the material risk inherent in the proposed treatment; a risk being material if, in the circumstances of a particular case:
>
> a) A reasonable person in the patient's position, if warned of the risk, would be likely attach significance to it; or
> b) The medical practitioner is or should reasonable be aware that the particular patient, if warned of the risk, would be likely to attach significance to it."

As stated above the requirement of consent before treatment is well established in our law. The early principles emerged through the common law with the first case being **Stoffberg v Elliot.**[10] These common law consent norms have been developed through the civil law and the defence of *volenti non fit injuria* (this means that no injury is committed against one who consents).[11] This doctrine states that if someone willingly places themselves in a position where harm might result, knowing that some degree of harm might result, they are not able to bring a claim against the other party in delict.[12]

With the advent of democracy that came with the elections of 1994 which, for the very first time, included participation from all races in South Africa, came several new pieces of legislation aiming at redressing the injustices of the past apartheid[13] government. With regards to changes to patients' rights some of the most fundamental patient rights are now contained

[9] Castell v De Greef 1994 (4) SA 408 (C) at page427.
[10] 1923 CPD 148.
[11] Santam Insurance Co. LTD v Voster 1973 (4) SA 764 (A).
[12] *Ibid.*
[13] Apartheid was a systematic exclusion and discrimination of people based solely on race. Non-whites experienced it on a daily basis, at work, in public places and in their homes. Some were forcibly removed from their homes to make way for the privileged minority; South Africa was in turmoil. It continued to exist in South Africa until 27th April 1994 when the first democratic elections were held, culminating in the new South African Constitution that was adopted in 1996.

within the National Health Act.[14] The Act was promulgated 'to provide a framework for a structured uniform health system within the Republic, taking into account the obligations imposed by the Constitution and other laws on the national, provincial and local government with regard to health services; and to provide for matters connected therewith'.[15] In other words the purpose of the National Health Act is to move away from our Apartheid past of unequal and unjust allocation of health services to a new era in which health care is provided in line with the rights in the Constitution.

If consent is not obtained, or failure to respect a patient's right to bodily integrity may lead to an ethical complaint to the Health Professions Council of South Africa (HPCSA), criminal proceedings for assault, or to a civil claim for damages.[16]

1.2 LITERATURE REVIEW

Strode *et al* submit that the right only to receive medical treatment with informed consent is founded in the Constitution, health laws and common law.[17] They further assert that legally, consent operates both positively as a patient's right and negatively as a defence protecting health care workers (*volenti non fit injuria*- to one consenting no wrong is done).[18]

Writers have suggested that there has been a shift from medical paternalism to patient autonomy.[19] Chima argues further that our approach to consent should be based on a shift from medical paternalism to patient autonomy;[20] an acceptance that the standard in our civil law is now not one of the reasonable doctor but the 'prudent patient' standard[21] and a move to the disclosure of the "material risk" standard, where the level of disclosure required is what a

---

[14] Act 61 of 2003.
[15] *Ibid* Preamble.
[16] 'Consent to Medical Treatment in South Africa'; *A Medical Protection Society Guide,* (2010) at page 3, https://www.medicalprotection.org > *S.A-booklets accessed on 11 August 2021*.
[17] Strode *et al* "She made up a choice for me": 22HIV-positive women's experiences of involuntary sterilization in two South African provinces' (2012). Reproductive Health Matters, 20 (39S): 61-69 at page 62.
[18] *Ibid.*
[19] S. Chima. 'Evaluating the quality of informed consent and contemporary clinical practices by medical doctors in South Africa: An empirical study' (2013) *BMC Medical Ethics* 14 (S1):1-17 at page 3.
[20] *Ibid* at page 3
[21] *Ibid* at page 3

reasonable patient would consider pertinent before making a decision.[22] In a similar vein other authors such as Mamooje submit that the National Health Act specifies that informed consent is required before performing any procedure on a patient.[23] Britz takes a similar position to Mamooje, viewing consent as a fundamental autonomy right.[24] He states further that self-determination, the rights to bodily integrity and moral agency are now accepted as fundamental rights of every patient.[25] Britz suggest further that it is also accepted that health care workers have a legal duty to obtain a patient's consent for any medical intervention.[26]

Much of the literature focuses on the reasons why consent is so significant. Ganya *et al* suggest that the doctrine of informed consent holds that persons are their own sovereign and should thus be allowed to make the final decision on affairs concerning them providing that the elements required for informed consent to medical treatment (or informed refusal of treatment) have been satisfied.[27] These elements include[28]:

I. Competence;
II. Disclosure of information;
III. Understanding and appreciation of the information disclosed;
IV. Voluntariness in decision-making; and
V. Ability to express a choice.[29]

In view of the above elements, it may safely be declared that informed consent has occurred when a competent person has received thorough disclosure, understands and appreciates the disclosure, acts voluntarily, and consents to the intervention.[30]

[22] *Ibid* at page 3
[23] Mamojee *et al* 'Anaesthetists' knowledge of South African Law pertaining to informed consent in an academic centre' (2018) Southern African Journal of Anaesthesia and Analgesia 24(6):155-165 at page 157
[24] Ibid at page 157
[25] Britz *et al* 'Voluntary Informed Consent and good clinical practise for clinical research in South Africa: Ethical and legal perspectives' (2012) South African Medical Journal 102(9): 746-748 at 746.
[26] *Ibid* at page 746
[27] W Ganya, S Kling and K Moodley 'Autonomy of the child in the South African Context: is a 12-year-old of sufficient maturity to consent to medical treatment' (2016) BMC Medical Ethics Vol17 Article No.66:1-8 at page 4
[28] *Ibid* at page 4
[29] *Ibid* at page 4
[30] T L Beauchamp, J F Childress *Principles of Biomedical Ethics* Oxford University Press 7th Edition 2001, pages 10-18.

Another key theme in the literature relates to the complexities of obtaining consent from children. Ganya *et al* describe a child as a developing person with evolving capacities that include autonomy, mental (decisional) capacity and capacity to assume responsibilities, hence children are entitled to participatory (autonomy) rights in South Africa as observed in the Children's Act 38 of 2005.[31] In the past, when the Child Care Act 75 of 1983 was still in effect, only children above the age of 14 years could consent to medical treatment.[32] Ganya *et al* suggest further that what necessitated law reform was the realisation of a number of shortcomings experienced with the Child Care Act and a need to fully acknowledge children as rights-holders.[33] This resulted in a lower threshold for age of consent being promoted and thus seen as a means to promote access to health services, promote participation of children in health decisions affecting them in accordance with international trends.[34]

When it comes to children and consent to medical treatment the Children's Act 38 of 2005 makes specific provisions regarding obtaining the informed consent of children to medical treatment and surgery. This is set out in Section 129 of such Act. According to MacQuoid-Mason, the Children's Act provides that children may consent to medical treatment of themselves or their children if they are 12 years of age or more and of sufficient maturity and with the mental capacity to understand the benefits, risks, and social or other implications of such treatment[35].[36] Concerningly, even though children are a vulnerable group, a research by Chima *et al* found that 71% of doctors and 30% of nurses could correctly identify the age of consent for routine medical treatment. Similarly, only 30% of doctors and 8% of nurses knew the age of consent for termination of pregnancy.[37]

[31] W Ganya, S Kling and K Moodley. 'Autonomy of the child in the South African Context: is a 12 year old of sufficient maturity to consent to medical treatment' (2016) BMC Medical Ethics Vol17 Article No.66:1-8 at page 3.
[32] *Ibid* at page 3
[33] *Ibid* at page 3
[34] *Ibid* at page 3
[35]D. McQuoid-Mason. 'Provisions for consent by children to medical treatment and surgical operations, and duties to report child and aged persons abuse' (2010) South African Medical Journal 100 (10) 646-648 at page 646.
[36] Section 129(2) of the Children's Act 38 of 2005.
[37] S.C Chima 'Understanding and Practice of Informed Consent by Professional Nurses in South Africa: An Empirical study-brief report' (2017) The International Academic Forum pages 1-14 at page 10.

Another area covered in the literature is obtaining consent from persons who are mentally ill or do not have capacity. Like children there are many complexities in obtaining consent from this group. A key issue raised by authors is the capacity to make autonomous decisions.[38] This does not however necessarily imply that a person will govern him/herself, and such capacity may be constrained temporarily by factors such as illness, ignorance, coercion or limited conditions.[39] Van Staden and Kruger both agree that some mental conditions prevent patients from understanding the nature and purposes of the proposed medical intervention, or prevent patients from communicating their consent.[40] Davidson adds that although treatment without consent cannot be provided under the Mental Health Care Act of 2002 unless a person either provides consent or lacks the requisite capacity, the balance is clearly in favour of treatment.[41] The above writers agree that informed consent to medical treatment requires more than mere capacity, it requires that a mental disorder does not prevent actual understanding of what is being consented to (rather than a mere capacity to consent).[42] Furthermore, incapacity to give informed consent extends to incapacity to give informed consent to medical interventions for mental as well as physical conditions.[43]

Key human rights issues in the literature include concerns over the failure of doctors to obtain consent as required by law. Recently there have been many reports of HIV positive women being coerced into signing consent to sterilizations that they do not want.[44] Several articles show that health care workers have been obtaining consent by coercing HIV-positive women to be sterilized based on their (health care workers) misconceptions that (i) they are preventing HIV-positive children from being born, (ii) as HIV has an impact on one's life expectancy they

[38] D. Van Der Reyden. 'The Right to Respect for Autonomy', (2008) SA Journal of Occupational Therapy Vol 38(1): 24-31 at page 27.
[39] *Ibid* at page 27
[40] C W Van Staden, C Kruger. 'Incapacity to give consent owing to mental disorder' (2003) Journal of Medical Ethics 29 (1) 41-43 at page 41.
[41] L Davidson. 'Capacity to consent to or refuse psychiatric treatment: an analysis of South African and UK law' (2017) South African Journal on Human Rights 32 (3) 457-489 at page 457.
[42] *Ibid* at page 457
[43] C W Van Staden, C Kruger. 'Incapacity to give consent owing to mental disorder' (2003) Journal of Medical Ethics 29 (1) 41-43 at page 42.
[44] C.J Badul, A. Strode 'LM & Others v Government of Namibia: The first Sub-Saharan African case dealing with coerced sterilization of HIV-positive women – quo vadis?' African Human Rights Journal (2013) (1): 214-228 at page 216.

are avoiding orphans as a result of HIV (iii) the women should not expose themselves to harm by carrying a child.[45]

Mamoojee *et al* submit that the administration of anaesthesia is considered to be a procedure; therefore, anaesthetists are expected to be familiar with laws governing informed consent to medical treatment.[46] A study made by Naidu and Gopalan at eThekwini Municipality found that the current practise by which consent to anaesthesia is obtained is through an informal interaction between the patients and doctor.[47] From the study it was found that 47% of the doctors felt that consent to surgery implied consent for anaesthesia. Naidu and Gopalan further submits that although surgery and anaesthesia are functionally linked processes, separate consent processes are mandatory.[48] This clearly shows that doctors do not understand that consent must cover all aspects of the procedure, from anaesthetics, medical treatment and surgery.[49] This may be because while consent is the first step in the treatment of patients, it is often viewed by health care workers as a time waster and an impediment in treating urgent health afflictions where life and death are at stake.[50] In other instances there are no interpreters to adequately explain to the patient the course of treatment, the likely side effects and the possible prognosis; most patients sign consent forms for surgery on a stretcher on their way to the operating room.[51] It is for this reason that adequate training of health care workers into laws regarding consent to medical treatment, surgery and all aspects of medical practitioner-patient relationship ought to be done. This would be beneficial for them (to mitigate against civil suits) and beneficial for the patient to know exactly what he is signing up for.[52]

---

[45] C.J Badul, A. Strode 'LM & Others v Government of Namibia: The first Sub-Saharan African case dealing with coerced sterilization of HIV-positive women – quo vadis?' African Human Rights Journal (2013) (1): 214-228 at page 216.
[46] A Mamoojee, A. Alli. 'Anaesthetist's knowledge of South African Law pertaining to informed consent' (2018) South African Journal of Anaesthesia and Analgesia.24 (6) 155-164 at page 155.
[47] S. Naidu, P.D Gopalan 'The perspectives of eThekwini public service anaesthetic doctors on the informed consent process for anaesthesia' (2013) Southern African Journal of Anaesthesia and Analgesia Vol 19(2): 96-101 at page 97.
[48] *Ibid* at page 97.
[49] *Ibid* at page 97.
[50] *Ibid* at page 97.
[51] *Ibid* at page 97.
[52] *Ibid* at page 97.

1.3 AIMS, OBJECTIVES AND RESEARCH QUESTIONS

This dissertation aims to critically review whether consent laws (in respect of medical treatment) in the post 1994 legal framework protect patients. This aim will be achieved through attempting to answer the following research questions:

(i) Is there a positive right to consent or is consent simply a defence which may be used to justify an otherwise unlawful conduct?

(ii) Has there been a shift to a recognition of consent to medical treatment being a positive right through various post-1994 pieces of legislation?

*(iii)*Does the current law protect patient rights to autonomy?

1.4 RESEARCH METHODOLOGY

The type of research method used in this dissertation is Experimental Qualitative research method. In qualitative research the researcher tries to explore and understand the meaning individuals or groups ascribe to social and human problems or an individual's perception of the world.[53] Using this method this study sought to examine consent to medical treatment by patients and the legal framework protecting such rights to consent. This research method uses non numerical data to understand concepts, opinions and experiences.

Based on this approach this study will involve the analysis of legislation dealing with informed consent, examining the impact of such legislation to capacity to consent to and refuse treatment; impact of such legislation on the legally and constitutionally protected patient rights and the impact of common law. Further an analysis of the defences that may be raised by health care workers when confronted with litigation where allegations of lack of consent by patients are placed before them; this will be done through discussions on case law.

---

[53] S. Chima. 'An investigation of Informed Consent in clinical practise in South Africa' (PhD Thesis, University of South Africa, 2018) at page 235.

1.5 OUTLINE OF CHAPTERS

Chapter 1 : INTRODUCTION

Chapter 2 : LEGAL FRAMEWORK FOR CONSENT TO MEDICAL TREATMENT

Chapter 3 : DISCUSSION AND ANALYSIS

Chapter 4 : CONCLUSION

CHAPTER TWO

THE LEGAL FRAMEWORK FOR CONSENT TO MEDICAL TREATMENT

Patient's rights may be defined as a combination of claims, liberties, powers and immunities that ensure the protection of the patient's dignity and moral autonomy.[54] Precisely to protect the rights of all people in our country and to affirm the values of human dignity, equality and freedom, the South African Constitution includes a Bill of Rights that outlines numerous provisions related to the right to health.[55] The right to health includes, not only access to healthcare services, but to many of the social determinants of health, such as adequate water, social security, housing and education as well as foundational rights such as dignity, equality and life.[56]

2.1 THE CONSTITUTION

The Constitution of the Republic of South Africa, 1996 recognises both autonomy and self-determination in the provisions of the right to bodily and psychological integrity[57] which includes the right to control over one's body; the right to privacy[58], and the right to life.[59] As a founding value of the Constitution the right to human dignity in section 10 is highly relevant within the healthcare context.[60] In as far as health and treatment is concerned, section 27(3) of the Constitution of the Republic of South Africa makes provision that no one may be refused emergency medical treatment. This will be discussed later on in this dissertation when capacity to consent to or refuse treatment is discussed, and the definition of emergency medical treatment in light of the provisions of the National Health Act, sections 6, 7 & 8.

---

[54] S.C Chima. "Because I want to be informed, to be part of the decision-making": Patients insights on informed consent practices by healthcare professionals in South Africa', (2015) Nigerian Journal of clinical practice Vol.18 (7): 46-56 at page 48.
[55] K. Moodley. *Medical Ethics, Law and Human Rights*; 2nd Edition 2017 at page 115.
[56] *Ibid* at page 115
[57] Section 12 of the Constitution of the Republic of South Africa 1996.
[58] Section 14 of the Constitution of the Republic of South Africa 1996.
[59] Section 11 of the Constitution of the Republic of South Africa 1996.
[60] W. Moore et al. 'Medical Information Therapy and Medical Malpractice litigation in South Africa' (2013) South African Journal of Bioethics and Law, Vol 6 (2): 60-63 at page 61.

(a) The Right to dignity

Section 10 of the Constitution of the Republic of South Africa 1996 provides that:

> "Everyone has inherent dignity and the right to have their dignity respected and protected".

Human dignity is best understood as a specific species of dignity that denotes the objective value *inherent* to all humans.[61] Human dignity entails that an individual is entitled to autonomy.[62] Autonomy, in turn, means that every person should be able to pursue his or her idea of a good life.[63] The case of **Stransham-Ford v Minister of Justice and Correctional Services**[64] best illustrates the right to human dignity. The High Court in this case relied heavily on human dignity, and adhered to the meaning of human dignity qua autonomy[65], the right to choose to refuse treatment.[66] Our Constitutional Court has refrained from specifically defining human dignity, but the meaning of human dignity has gradually crystallised through the Court's jurisprudence, resulting in us being able to identify the following elements of dignity, it includes that all individuals are:[67]

a) an end in himself or herself;
b) entitled to equal concern;
c) entitled to a space for self-actualization;
d) entitled to self-governance and autonomy; and
e) collectively responsible for the material conditions for individual agency[68].

Dignity is not only one of the founding values of the Constitution 1996, it is also an independent, self-standing, enforceable right.[69] At the heart of the right to dignity is the assumption that each human being has incalculable human worth, regardless of circumstances,

---

[61] D.W Jordaan. 'Human Dignity and the future of the voluntary active euthanasia debate in South Africa' (2017) South African Medical Journal; 107 (5) 383-385 at page 383.
[62] *Ibid* at page 384.
[63] *Ibid* at page 384
[64] 2015 (4) SA 50
[65] D.W Jordaan. 'Human Dignity and the future of the voluntary active euthanasia debate in South Africa' (2017) South African Medical Journal; 107 (5) 383-385 at page 383
[66] *Ibid* at page 384
[67] *Ibid* at page 384.
[68] *Ibid* at page 384
[69] P. De Vos & W. Freedman *South African Constitutional Law in Context*, 2nd Edition, Oxford University Press 2021 at page 562.

and should be treated accordingly.[70] This idea or value is at the inner heartland of our rights culture.[71] South African constitutional jurisprudence does not require a litigant to choose only one right to rely on, which means that a litigant may invoke the right to dignity alongside one or more of the other rights contained in the Constitution.[72] There will, nevertheless, be some situations in which the harm cannot be specifically addressed by another right and in these cases the litigant will have to rely exclusively on the right to dignity to attack the constitutional validity of law or conduct.[73] **Dawood and Another v Minister of Home Affairs and Others**; **Shalabi and Another v Minister of Home Affairs and Others**; **Thomas and Another v Minister of Home Affairs and Others**[74] is an important case for the purpose of illustrating the fact that dignity operates as both a right and value in our constitutional sphere.[75] While many of these indignities will amount to unfair discrimination and could be dealt with under section 9(3) of the Constitution, section 9(3) could be invoked in such cases alongside the right to human dignity in section 10 of the Constitution[76], but where the dignity cannot neatly fit into the section 9(3) framework, a court may extend the scope of the right to human dignity in cases it deems appropriate.[77] Finally, it should be noted that there is a close link between human dignity and the right to privacy in our constitutional order.[78] As the right to privacy recognises that human beings have a right to a sphere of intimacy and autonomy that should be protected from invasion, it is a right that fosters human dignity.[79]

(b) The right to bodily integrity

Section 12(2) of The Constitution of the Republic of South Africa 1996 provides that:

[70] *Ibid* at page 562
[71] Masethla v President of the Republic of South Africa and Another 2008 (1) SA 566 (CC) at paragraph 98.
[72] P. De Vos & W. Freedman *South African Constitutional Law in Context*, 2nd Edition, Oxford University Press 2021 at page 565.
[73] *Ibid* at page 565

[74] CCT35/99 (2000) ZACC 8.
[75] Khumalo and Others v Holomisa (2002) ZACC 12 at paragraph 27.
[76] P. De Vos & W. Freedman *Constitutional Law in Context*, 2nd Edition, Oxford University Press 2021 at page 569.
[77] *Ibid* at page 569
[78] *Ibid* at page 569
[79] Khumalo and Others v Holomisa (2002) ZACC 12 at paragraph 27; Minister of Justice and Constitutional Development and Others v Prince (Clarke and Others Intervening) (CCT108/17) [2018] ZACC 30; National Director of Public Prosecutions and Others v Rubin 2018 (6) SA 393 (CC); National Director of Public Prosecutions and Others V Acton 2018 (10) BCLR 1220 (CC).

"Everyone has the right to bodily and psychological integrity, which includes the right-

(a) To make decisions concerning reproduction;

(b) To security in and control over their body; and

(c) Not to be subjected to medical or scientific experiments without their informed consent".[80]

The right to physical integrity as enshrined in Section 12(2)(b) of the Constitution of the Republic of South Africa 1996 is the foundation on which jurisprudence concerning patient autonomy – and the right to consent to or refuse treatment rests.[81] The right to bodily integrity necessitates a right to give or with-hold informed consent, before any procedure is undertaken, or another process affecting one's body begins.[82]

Two Judgments spring to mind when the rights in section 12(2)(b) and (c) are concerned. Both deal with the constitutional right to bodily integrity. The one is the matter of **Minister of Safety & Security v Gaqa**[83] and the other is **Minister of Safety & Security v Xaba**.[84] The Gaqa matter was a criminal case where the police wanted to remove a bullet from the respondent in order to use it in his prosecution. The brief facts were that the State had applied to court for the surgical removal of a bullet lodged in the leg of the respondent who was a suspect in a botched robbery that ended in a double murder. The allegation was that one of the deceased owned a .38 revolver which he had used to fire shots at his assailants injuring one, believed to be the respondent. The respondent had refused to consent to the surgical removal of the bullet hence the application by the state. The court adopted a view that "police are obliged to investigate crime, in this instance a double murder, in terms of Section 205 (3) of the Constitution of the Republic of South Africa 1996, and without the bullet, they may be hamstrung in fulfilling this constitutional duty"[85] The court applied the provisions of section 36(1) of the South African Constitution thus finding that:

---

[80] Section 12(2)(a) to (c) of the Constitution of the Republic of South Africa 1996.

[81] A Nienaber. 'The right to physical integrity and informed refusal: Just how far does a patient's right to refuse medical treatment go?' (2016) South African Journal of Bioethics and Law, Vol.9 73-77 at page 73.

[82] *Ibid* at page 73

[83] (2002) ZAWCHC 9

[84] 2004 (1) SACR 149 (D).

[85] Minister of Safety and Security v Gaqa [2002] ZAWCHC 9.

> "…it is apparent that a refusal to assist the applicant in this case will result in serious crimes remaining unsolved, law enforcement stymied and justice diminished in the eyes of the public who have a direct and substantial interest in the resolution of such crime. Respondent's interests in all circumstances, are of a lesser significance. Though the intrusion is substantial, community interests must prevail in this instance".[86]

A different approach however was adopted in **Minister of Safety & Security v Xaba**.[87] The courts in both cases were confronted with applications where the police wanted an accused person to undergo a surgical procedure to remove a bullet to be used in their prosecution.[88] In the Xaba case the applicants sought confirmation of a *rule nisi* which would declare the second applicant, a police officer, to be entitled to "use reasonable force, including any necessary surgical procedure performed by medical doctors to remove a bullet lodged in respondent's thigh".[89] The respondent was a suspect in a motor vehicle hijacking case and the police believed the bullet would connect him to the crime. The applicants relied on Section 27 of the Criminal Procedure Act 51/1977 which deals with the legitimate use of force by police in the event of resistance against search or seizure and Section 37 which deals with the police powers in respect of prints and bodily features of the accused. The court held that Section 12 of the Constitution would clearly be infringed if the proposed surgery were to take place without the respondent's consent and not under some law limiting its protection as intended in Section 36 of the Constitution.[90] Southwood J went further, holding that the decision in **Minister of Safety & Security v Gaqa**[91] in which a court concluded that section 27 and 37(1)(c) allowed a police official to use necessary violence to obtain the surgical removal of a bullet in circumstances similar to those in the instant case, was wrong and should not be followed.[92] In this case the court followed a formalistic approach, basing its finding on a technical reading of the legislation and holding that the phrase, "including the taking of a blood sample" in section 37 of the Criminal Procedure Act showed the legislature's intention that taking a blood sample

---

[86] Minister of Safety and Security v Gaqa [2002] ZAWCHC 9.
[87] 2004 (1) SACR 149 (D).
[88] S.C Chima. 'An investigation of Informed Consent in Clinical Practice in South Africa' (PhD Thesis University of South Africa 2018) at page 166.
[89] Gaqa op cit note 85 at paragraph 1.
[90] Xaba op cit note 86 above, at paragraph 155 e-j.
[91] 2002 (1) SACR 654 (C).
[92] *Ibid.*

was the only medical procedure allowed in terms of this section.[93] The court further held, at paragraph 714 d-f in the absence of a supplied definition, the word "search" in section 27 had to be given its ordinary meaning, which does not include surgery or other medical procedures.[94] The *rule nisi* was accordingly discharged.

Section 12(2) is concerned more broadly with individual autonomy, and thus the right to make free and informed choices about one's body and one's psychological well-being.[95] When restrictions are placed on what decisions a person is permitted to make about their own body, or a person is stifled in making other important decisions about their life, such as whether they wish to disclose an illness or not, section 12(2) is implicated.[96] Section 12(2) thus helps to give effect to the principle that the agency of each individual should be protected.[97] It is concerned with the integrity of each person, affirming the equal worth of all individuals regardless of bodily or other differences.[98] But when read with section 7(2) of the Constitution it becomes clear that the right requires more than mere tolerance of diverse bodies and states of mind, but instead places a positive duty on the state to ensure that everybody is able to participate fully in society.[99] Because of the history of discrimination against certain types of bodies, this means that the section imposes an obligation on the state to ensure that the ability of some individuals fully to participate in society is not hampered by the so-called "neutral" laws that have a disparate impact on specific groups of individuals.[100]

2.2 CHILDREN'S RIGHTS

Section 28(3) of the Constitution of the Republic of South Africa 1996 describes a child as a person under the age of 18. Section 28(2) provides that "A child's best interests are of paramount importance in every matter concerning the child". The Children's Act now allows sufficiently mature children of 12 years of age to consent to medical treatment, and to consent

[93] A Nienaber. 'The right to physical integrity and informed refusal: Just how far does a patient's right to refuse medical treatment go?'(2016) South African Journal of Bioethics and Law, Vol.9 73-77 at page 75.
[94] *Ibid* at page 75
[95] AB and Another v Minister of Social Development (CCT155/15) [2016] ZACC 43.
[96] *Ibid* at page 75
[97] P. De Vos & W. Freedman *Constitutional Law in Context*, 2nd Edition, Oxford University Press 2021 at page 584.
[98] *Ibid* at page 584
[99] *Ibid* at page 584
[100] *Ibid* at page 584

to surgical operations with the assistance of their parent or guardian.[101] The Children's Act provides that a child who: (i) is 12 years old or older; (ii) is of sufficient maturity and (iii) has the mental capacity to understand the benefits, risks, social and other implications may consent to medical treatment without consent from a parent, guardian or caregiver or the assistance of a parent or guardian.[102] Section 9 of the Children's Act sets out the 'best interests of the child standard', which requires, among other things , that the following be taken into account (i) the child's age, maturity and stage of development, gender, background, and any other relevant characteristics, (ii) the child's physical and emotional security and his or her intellectual, emotional, social, and cultural development, (iii) any disability the child may have and (iv) any chronic illness from which the child may suffer (section 7(1)).[103] The relevant factors listed in the Act for assessing the best interests of the child standard may assist a healthcare provider in deciding whether a child of 12 years of age or more is 'of sufficient maturity' and has the necessary 'mental capacity' to give informed consent.[104]

2.3 LIMITING THE RIGHTS IN THE CONSTITUTION

It is trite law that the right to physical integrity, like other human rights in the Bill of Rights[105], may be limited under certain circumstances. The limitation of rights is a necessity for a functional and effective system of government.[106] The limitation of rights in the Bill of Rights is provided for in Section 36 of the Constitution which provides as follows:

> 36(1) "The rights in the Bill of Rights may be limited only in terms of law of general application to the extent that the limitation is reasonable and justifiable in an open and democratic society based on human dignity, equality and freedom, taking into account all relevant factors, including
>
> a. The nature of the right;
>
> b. The importance of the purpose of the limitation;

---

[101] D. MacQuoid-Mason. 'Provisions for consent by children to medical treatment and surgical operations, and duties to report child and aged persons abuse' (2010) Vol 100(10): 646-648 South African Medical Journal, at page 646.

[102] D. MacQuoid-Mason. 'Can children 12 years or more refuse life- saving treatment without consent or assistance from anyone else?' (2014) South African Medical Journal 104(7): 466-467 at page 466.

[103] *Ibid* at page 466

[104] *Ibid* at page 466

[105] This refers to the rights in Chapter 2 of the Constitution of the Republic of South Africa 1996.

[106] A Nienaber. 'The right to physical integrity and informed refusal: Just how far does a patient's right to refuse medical treatment go?' (2016) South African Journal of Bioethics and Law, Vol.9 73-77 at page 74.

c. The nature and extent of the limitation;

d. The relation between the limitation and its purpose; and

e. Less restrictive means to achieve the purpose."[107]

This section is applicable to all rights contained in the Bill of Rights, this means that every time a limitation of a person's right to dignity or bodily integrity is contemplated or occurs, judicial intervention is possible to measure the limitation against section 36, and to ensure compliance with the Constitution.[108]

By law a patient can refuse treatment if this will affect nobody but the patient themselves, John Stuart Mill supports this in his famous 'harm principle' which states that: "the only purpose for which power can be rightly exercised over any member of a civilised community, against his will, is to prevent harm to others.[109] This is also true with the provisions of Section 7(1) (d) & (e) of the National Health Act 63 of 2003[110]

Clarke v Hurst[111] illustrates the limitation of the patient's right to consent to withdraw treatment. The brief facts are that Dr Clarke while undergoing an epidural block suffered cardiac arrest after a sudden drop in blood pressure. His heart stopped beating and he stopped breathing. His heart beat and breathing were restored after a successful resuscitation but by that stage he had suffered irreversible brain damage and was diagnosed as being in a permanent vegetative state.[112] He was in this state for a period of four years when his wife sought an order

[107] Section 36 of the Constitution of the Republic of South Africa 1996.
[108] *Ibid.*
[109] Mill J.S (1859) 'On Liberty' Penguin Publishers London 1984
[110] Section 7(1) (d) & (e) provide as follows:
7(1) Subject to Section 8, a health service may not be provided to a user without the user's informed consent, unless -
(d) failure to treat the user, or group of people which includes the user, will result in a serious risk to public health; or
(e) any delay in the provision of a health service to the user might result in his or her death or irreversible damage to his or her health and the user has not expressly, impliedly or by conduct refused that service.
[111] 1992 (4) SA 630 (D)
[112] A permanent vegetative state as described by Thirion J in Clarke v Hurst 1992 (4) SA 630 (D) at 640 D-F as "a neurological condition where the subject retains the capacity to maintain the vegetative part of neurological function but has no cognitive function. In such a state the body is functioning entirely in terms of its internal controls. It maintains digestive activity, the reflect activity of muscles and nerves for low level and primitive

that would give her authority to or withhold agreement to any medical treatment for him; to authorise the discontinuance of any present or future treatment including the discontinuance of any nasogastric feeding or hydration regime; and to act within these powers, despite the fact that the implementation of her decisions might hasten the death of the patient. Thirion J ruled that the discontinuance of an artificial feeding regime would not be the legal cause of death.[113]The court ruled further that in terms of the legal convictions of society it would not be wrongful or unlawful to discontinue any medical treatment or artificial feeding regime previously administered to the patient that had merely kept his body alive, and that it would be in the best interest of the patient's best interests to permit him to die.[114]It transpired during evidence that the patient had a living will directing that should he in future contract a terminal illness with no hope of recovery or become permanently unconscious, he should not alive by artificial means but be allowed to die.[115] This was, however not the basis of the court's decision.

2.4.1 The National Health Act 63 of 2003

The National Health Act provides a framework for a uniform health system in South Africa based on the obligations imposed by the constitution and other laws on the national, provincial and local governments with regard to health services.[116] The Act deals directly with consent to medical treatment in section 7 and is designed to ensure that the autonomy of the patient is respected and to avoid a paternalistic approach by doctors when obtaining consent.[117] Health practitioners will need to ensure that the above criteria are complied with by adopting a patient-centred approach to decision-making when soliciting consent from patients.[118]

---

conditioned responses to stimuli, blood circulation, respiration and certain other biological functions but there is no behavioral evidence of either self-awareness or awareness of the surroundings in a learned manner".

[113] Clarke v Hurst at 660 B-C. The court based its finding on the more flexible criterion for legal causation introduced in S v Mokgethi 1990 (1) SA 32 A, namely whether policy considerations of reasonableness, fairness and justice require that an act is viewed as the legal cause of a result.

[114] Clarke v Hurst at 653-657 and 660 D-F

[115] Louis Jordan 'The legal validity of an advanced refusal of medical treatment in South African Law (Part 1)' (2011) De Jure 3 at page 37

[116] D. MacQuoid-Mason, M.A Dada 'The National Health Act: some implications for family practice' (2006) CME Vol. 24 (1): 12-14 at page 12.

[117] *Ibid* at page 12

[118] *Ibid* at page 12

2.4.2 Consent to medical treatment

Section 6 of the National Health Act gives patients the right, before the patient is given any medical treatment, to be told of what treatment options are available to them, the benefits and risks of each treatment, and the costs of each treatment.[119] Sections 7 and 8 also indicate that patients have a right to participate in making any decisions regarding what treatment they want and that they must consent before any treatment is given to them, unless it is an emergency and they are unable to consent.[120] Section 9 recognises that there are times when patients can be forcibly admitted to a health establishment whether they consent or not.[121] It is important to note that a person can only be forced to be admitted to a health establishment or to receive treatment in exceptional circumstances, such as when that person is a danger to his or herself or to the public generally.[122]

In **Beukes v Smith**[123] the court had to decide whether the respondent, Dr Smith a surgeon who performed a laparoscopic hernia repair on the appellant Mrs Rabia Beukes was liable for damages for the alleged failure to provide the appellant with sufficient information so as to enable her to give informed consent to that surgery.[124] Mrs Beukes instituted a claim for damages against Dr Smith, alleging that the doctor had negligently omitted to inform her that the hernia repair could be done by way of a laparotomy procedure.[125] Such failure, so she contended, caused her to give uninformed consent as the alternative was less risky hence undergoing the surgery as she did [126] resulted in her suffering damages as a result of a colon perforation during that procedure.

The court was called upon to determine what Dr Smith imparted to Mrs Beukes and whether that constituted sufficient information to the appellant (Mrs Beukes) to enable her to give informed consent to the laparoscopy.[127] Specifically, against Dr Smith, the allegation was that

[119] A. Hassim et al *The National Health Act – A Guide*; Siber Ink Publishers for AIDS Law Project 2008 at page xv.
[120] A. Hassim et al *The National Health Act – A Guide* Siber Ink Publishers for AIDS Law Project 2008 at page xv.
[121] *Ibid* at page xv
[122] *Ibid* at page xv
[123] [2019] ZASCA 48.
[124] *Ibid.*
[125] *Ibid.*
[126] *Ibid.*
[127] *Ibid a*t paragraph 20.

he negligently elected to perform laparoscopic surgery instead of a laparotomy, despite the higher risk of bowel and vascular injury posed by the former on obese patients.[128] Dr Smith contended that Mrs Beukes gave him consent orally following an explanation by him of the contemplated laparoscopic surgery and the laparotomy option, together with the attendant material risks. The court concluded that the consent given by the applicant for the laparoscopy was consistent with what a reasonable person would have opted for immediately prior to surgery.[129] The court in finding for the respondent went further at paragraph 32 to state:

> "Viewed in light of the expert evidence, the information imparted by Dr Smith to Mrs Beukes, which the High Court rightly accepted, meets the standard of a reasonable expert. It covered a range of surgical procedures and treatment options available to Mrs Beukes and the associated benefits and risks. It could therefore not be said that there was negligence in relating to obtaining the informed consent from Mrs Beukes".

Section 6 of the National Health Act[130] requires that the information must be disseminated to the patient in order that he or she makes an informed choice. In other words this section of the Act reflects the inherent rights of patients in the Constitution to both dignity and bodily integrity. This section in effect codified the common law position regarding disclosure. The case of **Castell v De Greef**[131] established a patient-centred test for the disclosure of information. This test entails that a doctor should disclose all information and risks to which a reasonable person in the patient's position, if warned of these risks, would be likely to attach significance, or to which a reasonable doctor in the situation should be aware that the specific patient, if warned of these risks, would be likely to attach significance. The court stated further that any material risk must be disclosed. Section 6 of the National Health Act does not use the term material risks instead it states that patients must be informed of:

6(1)

> (a) "The user's health status except in circumstances where there is substantial evidence that the disclosure of the user's health status would be contrary to the best interest of the user;
>
> (b) The range of diagnostic procedures and treatment options generally available to the user;

[128]*Ibid a*t paragraph 9.
[129] *Ibid a*t paragraph 27.
[130] Act 61 of 2003.
[131] 1994 (4) SA 408 (CC).

(c) The benefits, risks, costs and consequences generally associated with each option; and

(d) The user's right to refuse health services and explain the implications, risks, obligations of such refusal".

This principle as enunciated in the Castell case was restated by the Supreme Court of Appeal in the more recent case of **Sibisi NO v Maitin**[132] which dealt with the meaning of informed consent to medical treatment in so far as it entails that the patient must be made aware of the risk of any procedure in order to make an informed consent. The court held that the standard test to be applied was whether a reasonable person in the position of the patient would choose a lesser invasive intervention if he or she is made aware of the risk[133]. In essence the court applied the principles of informed consent as established in **Castell v De Greef**[134]

The brief facts were that Sibisi sued a Dr Maitin for injuries to the arm of her daughter that was caused at birth when the doctor performed the McRoberts manoeuvre. The court was called

"to extend common law, so as to recognise that the test for whether the patient has given informed consent to a procedure, should be whether the reasonable patient in the position of the plaintiff would regard the risk as significant and elect not to undergo the procedure or follow a different mode of treatment.[135] The test would recognise the patient's right to autonomy and bodily integrity".[136] The court found, as negligence could not be established from the conduct of the respondent, there was no need to develop the common law test stated above, the appeal was accordingly dismissed.

2.4.3 Medical treatment without consent

Section 7 of the National Health Act provides exceptions to the general requirements of section 6 that no patient may receive treatment without consent. These exceptions are "if the patient is unable to give consent[137], the patient is unable to give consent and no one is mandated to give

[132] [2014] ZASCA 156.
[133] Sibisi v Maitin [2014] ZASCA 156 at paragraph 47 of the judgment.
[134] 1994 (4) SA 408 (CC).
[135] *Ibid* at paragraph 2.
[136] *Ibid* at paragraph 2
[137] Section 7(1)(a)(i) &(ii).

such consent[138], the provision of health care service is provided by an order of court[139], failure to treat the patient or group of people including the patient will result in a serious risk to public health[140], or any delay in the provision of health services to the patient might result in his or her death or irreversible damage to his or her health and the patient has not expressly, impliedly, or by conduct refused that service."[141]

Section 7 lists the groups of people who may give consent on behalf of a patient who is unable to give such consent by themselves. Such consent may be given by a person:

> "(a) (1)(i) mandated by the user to grant such consent on his or her behalf; or
>
> (ii) authorized to give such consent in terms of any law or court order
>
> (b) consent is given by a spouse or partner of the user, in the absence of a spouse or partner of the user, a parent, grandparent, an adult child or a brother or sister of the user, in the specific order as listed
>
> (c) the provision of a health service without informed consent is authorized in term of the law or court order".

2.5 THE CHILDREN'S ACT 38 OF 2005

2.5.1 Overview of consent to medical treatment by children

The Children's Act allows sufficiently mature children of 12 years of age to consent independently to medical treatment, and to consent to surgical operations with the assistance of their parent or guardian.[142] The Children's Act provides that "a child who: (i) is 12 years old or older; (ii) is of sufficient maturity and (iii) has the mental capacity to understand the benefits, risks, social and other implications may consent to medical treatment without consent from a parent, guardian or caregiver or the assistance of a parent or guardian".[143]

---

[138] Section 7(1)(b).
[139] Section 7(1)(c).
[140] Section 7(1)(d).
[141] Section 7(1)(c), (d) & (e) of the Act.
[142] D. MacQuoid-Mason. 'Provisions for consent by children to medical treatment and surgical operations, and duties to report child and aged persons abuse' (2010) South African Medical Journal Vol 100(10): 646-648, at page 646.
[143] D. MacQuoid-Mason. 'Can children 12 years or more refuse life- saving treatment without consent or assistance from anyone else?' (2014) South African Medical Journal 104(7): 466-467 at page 466.

Section 13 of the Children's Act affords "every child the right to:

a) Have access to information on health promotion and the prevention and treatment of ill-health and disease, sexually and reproduction[144];
b) Have access to information regarding his or her health status[145];
c) Have access to information regarding the causes and treatment of his or her health status[146]; and
d) Confidentiality regarding his or her health status and the health status of a parent, caregiver or family member, except when maintaining such confidentiality is not in the best interest of the child[147]".

Children may participate in an appropriate way in all matters concerning them, and any views expressed by them must be given due consideration.[148] However section 10 limits these right to children who are of such an age, maturity and stage of development as to be able to participate.[149] A person with parental responsibilities and rights in respect of a child must give due consideration to any views and wishes expressed by the child before making a list of specific decisions involving the child, bearing in mind the child's age, maturity and stage of development.[150]

Following is a table depicting the current legal position in so far as consent of children for medical and surgical treatment is concerned.[151]

Table1: Independent consent by children to medical treatment, surgery and procedures

[144] Section 13 (1)(a) of the Children's Act 38 of 2005
[145] Section 13(1)(b) of the Act
[146] Section 13 (1)(c) of the Act
[147] Section 13(1)(d) of the Act
[148] H. Kruger. 'The protection of children's rights to self-determination in South African law with specific reference to medical treatment and operations' (2018) Potchefstroom Electronic Law Journal. Vol 2: 1-34 at page 20.
[149] *Ibid.*
[150] Section 31(1)(a) of the Children's Act 38 of 2005.
[151] 'Consent to Medical Treatment in South Africa'; A Medical Protection Society Guide, (2010) at page 12, https://www.medicalprotection.org >sa- booklets accessed on 11 August 2021)

CURRENT LEGAL POSITION WITH REGARDS TO TREATMENT OF MINORS[152]			
Circumstances	**Age at which patient may consent**	**Relevant Legislation**	**Overview**
Medical Treatment	12	Section 129 of the Children's Act 28/2005	Consent to medical treatment starts at age 12 upwards in terms of this section.
Surgical Treatment	12	Section 129 of the Children's Act 28/2005	For surgical treatment the age is still 12 but with an additional consent of the parent or guardian.
HIV Testing	12	Section 130 of the Children's Act 38/2005	Consent for HIV testing may be given by a child 12 years or older; if younger, with sufficient maturity to understand the implications of the test.
Termination of pregnancy	No lower age limit	Section 5 of the Choice on Termination of pregnancy Act92/1996	There is no age limit for termination of pregnancy, the act only makes mention of a 'woman' meaning a female of any age can terminate pregnancy.

[152] *Ibid.*

Contraceptives	12	Section 134 of the Children's Act 38/2005	This section makes provisions for the issue of condoms or any form of contraceptives to children older than 12 years without parental consent.
Circumcision	16(for males only)	Section 12 of the Children's Act 2005	For male circumcision to be performed certain requirements have to be met. (this is not the focus group of this dissertation)
Minor with parental responsibility for a child	12	Section 129 of the Children's Act 38/2005	This section makes provisions for the consent of a child- parent for treatment of her child.
Sterilization	18	The Sterilization Act 44/1998 and the Sterilization Amendment Act 3/2005	It is clear that only adults can be sterilized, based on this Act. An adult is a person over the age of 18 according to section 17 of the Children's Act 38 of 2005

2.5.2 Consent by children under the age of 12

The child's parent, guardian or caregiver may consent to the child's medical treatment if the child is under the age of 12 years or over that age but of insufficient maturity, or is unable to understand the benefits, risks and social implications of the treatment.[153] Section 129(6) of the Children's Act provides that:

> "The Superintendent of a hospital or the person in charge of the hospital in the absence of the superintendent may consent to the medical treatment of or surgical operation on a child if-
>
> a) The treatment or operation is necessary to preserve the life of a child or to save the child from serious or lasting physical injury or disability; and

[153] Section 129(4) of the Children's Act 38 of 2005.

b) The need for the treatment or operation is so urgent that it cannot be deferred for the purpose of obtaining consent that would otherwise have been required".

The following classes of people may consent on behalf of children for medical treatment or surgical operations where the child is under the age of 12 or is over but insufficiently matured. These classes of persons are (i) the parent or guardian, (ii) in emergencies, the superintendent of a hospital, (iii) if the parent or guardian unreasonably refuses to give consent or assist, is incapable of doing so, cannot be readily traced or is deceased, the Minister of Social Development; and (iv) in all instances where another person who may give consent refuses or is unable to give such consent, a High Court or a Children's Court.[154]

2.5.3 The best interests of the child

Section 9 of the Children's Act sets out more detail relating to the constitutional principle of the "best interests of the child standard", which requires, among other things , that "the following be taken into account when determining the best interests of the child (i) the child's age, maturity and stage of development, gender, background, and any other relevant characteristics, (ii) the child's physical and emotional security and his or her intellectual, emotional, social, and cultural development, (iii) any disability the child may have ; and (iv) any chronic illness from which the child may suffer (section 7(1)".[155] The relevant factors listed in the Act for assessing the best interests of the child standard may assist a healthcare provider in deciding whether a child of 12 years of age or more is "of sufficient maturity" and has the necessary 'mental capacity' to give informed consent.[156]

2.5.4 Consent by children to surgical operations

In addition to the requirements in Section 129(2), for surgical operations the child must be assisted by his or her parent or guardian.[157] There is a comprehensive legal framework

[154] D. McQuoid-Mason. 'Provisions for consent by children to medical treatment and surgical operations, and duties to report child and aged persons abuse' (2010) South African Medical Journal Vol 100(10): 646-648 at 647.
[155] 'Consent to Medical Treatment in South Africa'; A Medical Protection Society Guide, (2010) at page 3, https://www.medicalprotection.org >sa-booklets accessed on 11 August 2021.
[156] *Ibid.*
[157] Section 129(3) provides that A child may consent to the performance of a surgical operation on him or her or his or her child if-
(a) The child is over the age of 12 years; and

addressing child consent to operations.[158] A strength of the approach is that it is consistent with one of the core principles underpinning the Children's Act that of a child's right to participate in decisions that affect him or her, as it provides that children with sufficient capacity can self-consent to an operation.[159] However, this focus on autonomy is not unfettered, as the protection of being assisted by a parent or guardian is required.[160] It is submitted that this is an important decisional support, and it provides parents with an opportunity to model good decision-making through asking questions, requesting clarity and engaging with the various factors that ought to be considered in the decision-making process.[161] A gap is that the framework does not define "duly assisted". Kruger[162] suggests that this refers to parental assistance with the consent process. She argues that as one of the parental responsibilities and rights is to care for the child and care is defined as guiding, advising and assisting the child in decisions to be taken by a child in a manner appropriate to the child's age, maturity and stage of development, assisting a child with consent falls naturally within the way in which the Children's Act envisaged the child/parent relationship.[163]

2.5.5 Refusal of treatment by children

Drawing from section 129(2) of the Children's Act a child is competent to refuse medical treatment if he or she is 12 years or older and of sufficient maturity to understand the risks and consequences of refusing treatment.[164] If the child is legally competent to refuse medical treatment, the refusal to undergo medical treatment, including life-saving treatment should be respected; however informed refusal of a child can be overridden by the court[165] or the minister of health.[166] Satisfying the age and maturity and understanding appear not to suffice, although

---

(b) The child is of sufficient maturity and has the mental capacity to understand the benefits, risks, social and other implications of the surgical operation; and
(c) The child is duly assisted by his or her parent or guardian.

[158]A. Strode, C.J Badul. 'Forms to capture child consent to surgical procedures: Time to focus on function rather than form' (2021) South African Journal of Bioethics and the Law 14(1):20-23 SAJBL.2021.v14i1.696.

[159] *Ibid* at page 696

[160] *Ibid* at page 696

[161] *Ibid* at page 696.

[162]H. Kruger. 'The protection of children's rights to self-determination in South African law with specific reference to medical treatment and operations' (2018) Potchefstroom Electronic Law Journal. Vol 21(1): 1-34 at page 24.

[163] *Ibid.*

[164] M. Buchner-Eveleigh. 'Is it a competent child's prerogative to refuse medical treatment?' (2019) De Jure Law Journal Vol 52 242-256 at page 243.

[165] Section 129(9).

[166] Section 129(8).

a legal requirement, as a decision made by a child who does satisfy these requirements can be overridden if the court is of the opinion that the treatment is in the best interests of the child.[167] When deciding the reasonableness or otherwise of the child's refusal of medical treatment, the Minister should judge it against the best interests of the child standard.[168]

2.5.6 Parents refusing medical treatment for children

It is submitted that during medical emergencies, the rights of patients not to be refused emergency medical treatment (section 27(3)) and to exercise their right to life (section 11), may not be undermined by their parent's right to freedom of religion (section 15(1)).[169] Subsequent to the judgment in **Hay v B**[170] the Children's Act has specifically outlawed refusal to consent solely on religious ground by parents or guardians to treatment of their children (section 129(10).[171] Section 129(10) provides that "No parent, guardian or caregiver of the child may refuse to assist the child or withhold consent by reason only of religious or other beliefs, unless that parent or guardian can show that there is a medically acceptable alternative choice to the medical treatment or surgical operation concerned". The Act places the onus squarely on the parent or guardian who objects to medical treatment or surgery being performed on a child to 'show that there is a medically acceptable alternative choice'.[172] It is submitted that this implies that parents or guardians who refuse to consent solely on religious grounds need to apply to court to prove that doctors have an alternative remedy, which is not being offered.[173]

In the more recent judgment in **Life Healthcare Group (PTY) Ltd and Another v JMS (as parent and guardian of the infant child MT) and Another**[174] the court had to decide whether it should authorize medical treatment for a child as a measure to preserve the child's life despite

[167] M. Buchner-Eveleigh. 'Is it a competent child's prerogative to refuse medical treatment?' (2019) De Jure Law Journal Vol 52 242-256 at page 250.
[168] D. MacQuoid-Mason. 'Can children 12 years or more refuse life- saving treatment without consent or assistance from anyone else?' (2014)South African Medical Journal 104(7): 466-467 at page 467.
[169] D. McQuoid-Mason. 'Parents refusing blood transfusions for their children solely on religious grounds: Who must apply for the court order?' (2020) South African Medical Journal 110 (2): 100-101 at page 100.
[170] 2003 (3) SA 492 (W).
[171] D. McQuoid-Mason. 'Parents refusing blood transfusions for their children solely on religious grounds: Who must apply for the court order?' (2020) South African Medical Journal 110 (2): 100-101 at page 100.
[172] *Ibid* at page 100
[173] *Ibid* at page 100
[174] [2014] ZAGP JHC 299.

the parent's objection to treatment for religious reasons.[175] The brief facts were that Dr Moodley testified to have been treating the child since birth by emergency caesarean at 28 weeks, weighing 1.3kg. The child had presented with respiratory distress and was immediately admitted at neonatal ICU. The child was facing imminent respiratory and cardiac failure and in urgent need of blood transfusion. Dr Moodley testified to have informed the parents of the child's condition and had also discussed with them the child's need for a blood transfusion. They objected to the child being transfused citing religious reasons. She had consulted with the parents about further alternatives to blood transfusion and explored all medical alternatives. The child's condition still did not improve, hence the application. The court held as follows:

> "It is in the best interest of the child that his life be preserved. Dr Moodley has done all she could to preserve the child's life without compromising the parent's right to religion by exploring all available medically acceptable alternatives to blood transfusion without success. The parent's objection falls squarely within the ambit of the prohibition in section 129(10). Their refusal to consent to blood transfusion for the child is unlawful".

McQuoid-Mason submits that if during medical emergencies doctors are refused consent by parents and guardians to treat young children who are incompetent to consent for themselves, and this is done *solely on religious grounds,* the doctors should counsel the parents or guardians that their conduct is unlawful, and advise them that while doctors will try to respect their religious feelings, if medical treatment is necessary to save the child's life, or to prevent it suffering severe physical injury or disability, such treatment will be undertaken without their consent.[176] Where the grounds for refusal are solely based on religion it is no longer necessary for doctors to seek a court order to overturn the parent's refusal as such refusal is unlawful.[177]

2.6 THE MENTAL HEALTH CARE ACT

The Mental Health Care Act 17 of 2002 governs consent to medical treatment by the mentally ill patients. This is provided for in section 9(1) of the Act. The Act has raised the issues and

[175] *Ibid* at paragraph 8.
[176] D. McQuoid-Mason. 'Parental refusal of blood transfusions for minor children solely on religious grounds – the doctor's dilemma resolve' (2005) South African Medical Journal Vol 95, No 1 at page 29.
[177] *Ibid* at page 29

profiles of mental health and serves as an advocacy for mental health care users.[178] The Act has, as one of his objectives to ensure that appropriate care, treatment and rehabilitation are provided at all levels of health service. In the case of involuntary treatment of mentally ill patients, because of impaired capacity and in the best interests of the patient and / society, paternalism tends to supersede autonomy.[179] The Mental Health Care Act is explicit in that only if a user is suffering from mental illness is the user eligible for involuntary treatment.[180] "Mental illness" means a positive diagnosis in accordance with accepted psychiatric diagnosis criteria which must be made by a mental health care practitioner authorized to make such diagnosis.[181]

Section 9(1) of the Mental Health Care Act No. 17 of 2002 makes provision for consent to medical treatment in respect of the mentally ill. How does one judge competence in the presence of mental illness?[182] Patient competence refers to the cognitive and emotional capacity to make an informed best-interest decision.[183] Beauchamp and Childress (2009) suggest seven "levels" of competence, briefly as follows[184]:

1. The patient can communicate a choice or preference (understanding, insight and judgment not evaluated).[185]
2. The patient can communicate and understand the situation and consequences of a decision.[186]
3. The patient can understand relevant facts and information about the illness and its treatment.[187]
4. The patient can give a reason for the decision.[188]
5. The patient can give a rational reason for the decision (which can be tested and contested).[189]

---

[178] MYH Moosa, FY Jeena. 'Involuntary treatment of psychiatric patients in South Africa' (2008) African Journal of Psychiatry 11:109-112 at page 110.
[179] *Ibid* at page 110
[180] *Ibid* at page 110
[181] *Ibid* at page 110
[182] Moodley K *Medical Ethics, Law and Human Rights* 2nd Edition [2017] at page 244.
[183] *Ibid* at page 244
[184] *Ibid* at page 244
[185] *Ibid* at page 244
[186] *Ibid* at page 244
[187] *Ibid* at page 244
[188] *Ibid* at page 244
[189] *Ibid* at page 244

6. The patient can give risk-benefit-related reasons for the decision.[190]
7. The patient can reach a reasonable decision (based on the reasonable person standard).[191]

2.6.1 Determining capacity to consent to medical treatment in psychiatric patients

It is not only the level of competence, but also the weight of the decision and the gravity of the outcome of the decision that determines whether a patient has the capacity to make an informed decision in her best interests.[192] By gravity of the decision one should consider the burden of illness and the burden of treatment, the treatability of the illness, the expected outcome/success of treatment, the benefit of treatment, and the impact of the illness on the patient's family and the community.[193] In psychiatric practice, therapists are often confronted with severely disordered patients who cannot make informed decisions and cannot act in their best interests because of illness.[194] It is advisable to temporarily treat the patient by obtaining consent from surrogate decision makers (closest family members) or to provide involuntary treatment for the sole purpose of restoring competence and good health, if possible, especially if the burden of illness is severe and the illness irreversible.[195] Consequently, if the patient, like most patients with psychiatric disorder, can provide informed consent to treatment, he or she should be managed as a voluntary patient and his or her autonomy respected.[196] If the patient is incompetent to make an informed decision, but does not refuse treatment, a surrogate decision maker (closest family member, guardian or curator) should assist in the treatment management by taking the responsibility for the decision on "best treatment" together with the clinician, and the patient can be admitted as an assisted mental healthcare user.[197] Should the patient be incompetent to make an informed decision and refuse treatment, the surrogate decision makers, together with the clinicians, should apply for the patient to be admitted as an involuntary patient until such time as the patient can become a voluntary patient.[198]

---

[190] *Ibid* at page 244
[191] *Ibid* at page 244
[192] Moodley K *Medical Ethics, Law and Human Rights* 2nd Edition [2017] at page 245.
[193] *Ibid* at page 245
[194] *Ibid* at page 245
[195] *Ibid* at page 245
[196] *Ibid* at page 245
[197] *Ibid* at page 245
[198] *Ibid* at page 245

2.6.2 Capacity to consent by psychiatric patients in light of the National Health Act

The National Health Act 63 of 2003 makes provision for certain persons to consent on behalf of mentally incompetent patients to an operation or medical treatment where such patients are unable to give the necessary consent and have not mandated, while still mentally competent somebody else in writing to give consent on their behalf.[199] Women with mental illness who become pregnant must often face the difficult decision of whether to take medications that may be helpful or necessary to treat their condition during pregnancy and during the postpartum period.[200] Women who are pregnant may have a greater sense of obligation to follow the wishes of their partner or family members regarding treatment of their mental illness and may be vulnerable to coercion.[201] The psychiatrist may be tempted to simplify or overstate the safety of the medication to encourage the patient to continue taking it in support of the ethical principle of *beneficence:* to help the patient and to protect her form the deterioration of her condition; however the ethical principle of *veracity* suggest that every attempt should be made to clearly state the risks and benefits of the medication to both the patient and the potential foetus.[202]

According to Appelbaum[203] the prevailing standard for the determination of decisional capacity regarding medical care relies on the presence of four key elements: (1) ability to communicate a choice, (2) ability to understand relevant information (factual understanding), (3) ability to appreciate the nature of the situation and its likely consequences (appreciation), and (4) ability to manipulate the information rationally. Capacity assessment should take into account whether and how women's underlying illness affects their capability to participate in an informed consent to medical treatment and allow for the natural process of evolution of decision-making in terms of adjustment to and acceptance of pregnancy.[204] When a pregnant woman lacks decisional capacity related to pregnancy, the first determination should be whether the lack of capacity is reversible and if so, the condition should be treated with

[199] Health Professions Council of South Africa. 'Guidelines for good practice in the health care professions: Seeking patient's informed consent: the ethical considerations' (2016) Booklet 4 pages 86-103 at page 96.
[200] M. Vemuri. 'Ethical Considerations in Treating Women with Mental Illness during Pregnancy' (2012) The Journal of Lifelong Learning in Psychiatry Vol X (1):36-40 at page 36.
[201] *Ibid* at page 36
[202] *Ibid* at page 36
[203] P.S Appelbaum. 'Assessment of patient's competence to consent to treatment' (2007) New England Journal of Medicine 357(18): 1834-1840 at page 1835.
[204] I. Zalpuri, N. Byatt and R. Brendel. 'Decision capacity in pregnancy: A complex case of pregnancy termination' (2015) Psychosomatics 56(3): 292-297 at page 296.

medication, psychotherapy and other appropriate treatments to restore capacity.[205] A thorough clinical assessment, including formulation of key issues, effect of termination on the patient and the distress related to it, and continued pregnancy, is critical to understanding the patient's framework of beliefs to guide decision making and to developing an ethically and legally sound plan for decision making.[206]

2.7 STERILISATION ACT

Section 4 of the Sterilisation Act 44 of 1998 provides the definition of what is meant by the word "consent". The offences and penalties for the contravention of the Sterilisation Act, more so section 4, can be found in section 9 thereof[207].

The judgment in the case of **Pandie v Isaacs[208]** deals with involuntary sterilization of a woman. The case is discussed more in detail in the analysis and discussion chapter.

2.8 THE CHOICE OF TERMINATION OF PREGNANCY ACT

The Choice of Termination of Pregnancy Act No.92 of 1996 states that a female of any age may consent to termination of pregnancy[209], such patient must be capable of giving consent.[210] If the child is not capable of giving such consent to a termination of pregnancy she must be told that her parent's or her guardian's consent is required, except in an emergency and / or if a parent or guardian cannot be contacted, when the procedure can be done without consent[211] or with the consent of a medical superintendent of a hospital.[212] In the case of **Christian**

---

[205] *Ibid* at page 296

[206] *Ibid* at page 296

[207] Section 9 of the Sterilization Act provides that 'Any person who contravenes or fails to comply with the provisions of this Act is guilty of an offence and liable on conviction to a fine or to imprisonment to a period not exceeding five years"

[208] [2013] ZAWCHC 123.

[209] Sections 5(2) and 5(3) of the Choice of Termination of Pregnancy Act 92 of 1996.

[210] D. McQuoid-Mason. 'Termination of pregnancy in children: Consent and confidentiality issues' (2010) South African Medical Journal Vol 100 (1): 213-214 at page 213.

[211] M.A Dada, D. McQuoid-Mason. 'Introduction to Medico-Legal Practice' (2001) Butterworths Publishers at page 16.

[212] D. McQuoid-Mason. 'Termination of pregnancy in children: Consent and confidentiality issues' (2010) South African Medical Journal Vol 100 (1): 213-214 at page 213.

Lawyers Association v Minister of Health[213] the essence of the plaintiff's case was that females under the age of 18 years are not capable, without parental consent or control, of making an informed decision as to whether or not to terminate their pregnancy serves their best interests.[214] It was held that in the context of the Choice of Termination of Pregnancy Act capacity to give informed consent is determined on a case-by-case basis by the medical practitioner, based on the emotional and intellectual maturity of the individual concerned rather than on an arbitrarily pre-determined and inflexible age.[215] The approach adopted by the *Choice Act* prevents frustration of the minor's constitutional rights where she is emotionally and intellectually capable of giving informed consent for the termination of her pregnancy.[216]

2.9 COMMON LAW

The first case dealing with the legal requirements of consent to medical treatment was **Stoffberg v Elliot.**[217] In this case doctors undertook a surgical procedure for which express consent had not been obtained. Although the patient had voluntarily admitted themselves to hospital, the doctor discovered a previously undiagnosed cancer of the penis while the patient was under a general anaesthetic. Assuming that the patient would then have a life expectancy of only two years without the amputation the doctor removed the penis to prevent the cancer from spreading. The patient subsequently sued the doctor for damages for failing to obtain his informed consent to the amputation. The court held that the patient was entitled to damages as the surgical procedure was performed without specific consent for the amputation.

In the case of **Christian Lawyers Association v Minister of Health**[218] the court stated as follows:

"The concept of informed consent is not alien to our common law, it forms the basis of the doctrine of *volenti non fit injuria*, conduct that would otherwise have constituted a delict or crime if it took place without the victim's informed consent. More particularly, day to day invasive medical treatment, which

[213] 2005 (2) SA 509 (T).
[214] C. Pickles. 'Termination-of-pregnancy rights and foetal interests in continued existence in South Africa: The Choice on Termination of Pregnancy Act 92 of 1996' (2012) Potchefstroom Electronic Law Journal Vol.15 (5): 402-435 at page 412.
[215] *Ibid* at page 412
[216] *Ibid* at page 412
[217] 1923 CPD 148.
[218] 2005 (2) SA 509 (T).

would otherwise have constituted an invasion of a patient's privacy and personal integrity, is justified and is lawful only because, as a requirement of law, it is performed with the patient's informed consent".

In terms of the common law, the legal elements of informed consent can be surmised as follows[219]:

a) Consent must be voluntary and without constraint;[220]
b) In the case of an HIV test, consent should preferably be written, although it may also be implied;[221]
c) Consent must not conflict with the *boni mores*(good morals of the community) or the values underlying the constitution;[222]
d) The patient must be capable of consenting;[223] meaning the consent must be made by someone understanding the nature of the treatment of surgery, must be legally capable of consenting; if a child, the requirements of Section 129 of the Children's Act should have been met.
e) The patient must give the consent personally, unless proxy consent is applicable;[224]
f) There should be sufficient information on the diagnosis, proposed treatment, expected benefits, risks, alternative treatment, probable results;[225] and
g) The patient must understand the information, i.e there is likely to be a need for an interpreter or at least sensitivity that the patient may not actually understand everything and arrangements should be made so as to assist the process of understanding.[226]

In **McDonald v Wroe**[227] the brief facts were that the plaintiff consulted with the defendant a general dental practitioner in regards to bouts of pericoronitis (infection) that she was

---

[219]'Consent to Medical Treatment in South Africa'; A Medical Protection Society Guide, (2011) at page 45, https://www.medicalprotection.org, >sa-booklets accessed on 15 August 2021.
[220] *Ibid* at page 45
[221] *Ibid* at page 45
[222] *Ibid* at page 45
[223]'Consent to Medical Treatment in South Africa'; A Medical Protection Society Guide, (2011) at page 45, https://www.medicalprotection.org >sa-booklets accessed on 15 August 2021.
[224] *Ibid* at page 45
[225] *Ibid* at page 45
[226] *Ibid* at page 45
[227] 2006 (3) ALL SA 565 (C).

experiencing in the area of her wisdom tooth.[228] The defendant as a course of treatment extracted part of the plaintiff's wisdom teeth[229]. Subsequent to the surgical procedure the plaintiff experienced numbness and "pins and needles" when touching the left side of her face. The medical experts agreed that the sequelae is permanent[230]. She subsequently sued the defendant, one of the causes was that the defendant had failed to inform the plaintiff of the possible complications and risks of the planned procedure, save to inform her that there might be considerable swelling[231]. At paragraph 7 of the judgment the court held as follows:

> "In South African law a medical practitioner has a duty to disclose a material risk of a planned procedure to the patient. This duty must be seen in the contractual setting of an unimpeachable consent by the patient to the procedure and its sequelae. See V**an Wyk v Lewis**, supra at 451 and **Castell v De Greef 1994 (4) SA 408 (C) AT425F**. For the consent to the planned procedure to constitute a justification that excludes wrongfulness of the medical treatment and its consequences, the medical practitioner is obliged to warn a patient do consenting of the material risks inherent in the proposed treatment".

Respect for autonomy and self-determination was introduced into our law in 1967 in **Richter & Another v Estate Hamman**[232] and subsequently secured in **Castell v De Greef**[233] in 1994.[234] Good medical practise requires the doctor to check that the patient has understood the information provided and has been offered an opportunity to seek clarification.[235] It is therefore not enough to just 'transmit' information- it is necessary to check whether the patient has both received it *and* absorbed it.[236] This flows from Section 6 of the National Health Act.

---

[228] *Ibid* at paragraph 1.
[229] *Ibid* at paragraph 1
[230] *Ibid* at paragraph 1
[231] *Ibid* at paragraph 1
[232] 1967 (3) SA 226 (C).
[233] 1994(4) SA 408 (C).
[234] H. Manyonga *et al* 'From Informed Consent to Shared Decision-making' (2014) South African Medical Journal Vol. 104 (8): 561-562 at page 561.
[235] *Ibid* at page 561
[236] *Ibid* at page 561

In **Lymbery v Jeferries**[237] the plaintiff, while undergoing X-ray treatment was burnt as a result of some eccentricity on her part which could not be foretold (evidence showed that the burns were rare). She instituted an action against the defendant, the medical practitioner who had referred her to the X-ray operator, on the ground that he was negligent in sending her to such an unqualified X-ray operator. The plaintiff alleged *inter alia* that the defendant had not informed her that the treatment was a dangerous one but the court *a quo* dismissed her claim. On appeal Wessels J held:

> "It may well be the duty of a surgeon before operating is to tell the patient that the operation is dangerous and may end in death…However, all the surgeon is called upon to do is give some general idea of the consequences. There is no necessity to point out meticulously all the complications that may arise".

Wessels J found at paragraph 240 of the judgment that there was no duty upon the X-ray operator to point out the possibility of burns as a result of X-ray treatment, as burning was rare. He further found that the defendant was not negligent as the X-ray operator was qualified to administer X-ray treatment, and confirmed the decision of the court *a quo*.

In **Richter v Estate Hamman**[238] the plaintiff had injured her coccyx on two separate occasions. First when she fell in a gymnasium when she was younger and then on a sharp edge of a chair. At first she was treated conservatively but was not satisfied with the treatment prescribed by her family doctor. Thereafter she contacted the defendant (Dr Hamman) who suggested an epidural block, which when administered did not relieve the tenderness she felt. The defendant thereafter administered a phenol block on the plaintiff's lower sacral nerves which relieved the coccygeal pain but also resulted in loss of control of the bladder and bowel, loss of sexual feeling, and loss of power in the right leg and foot. The plaintiff sued the defendant alleging that he was negligent in advising her to undergo a phenol block and failed to warn her of the dangers inherent in the procedure. She alleged that if she had known of the risks of the procedure she would not have consented to undergo the operation. Watermeyer J opined that the present action was not one relating to assault, and continued at paragraph 232 that:

[237] 1925 AD 236.
[238] 1976 (3) SA 226 (C).

> "It may well be that in certain circumstances the doctor is negligent if he fails to warn the patient, and, if that is so, it seems to me in principle that his conduct should be tested by a standard of a reasonable doctor faced with the particular problem".

Watermeyer J at paragraph 235 reasoned that since all expert witnesses held that the consequences were remote, it was not necessary for the defendant to warn the plaintiff of the possibility of complications. He dismissed the claim for lack of negligence on the part of the defendant.

CHAPTER THREE

3.1 ANALYSIS AND DISCUSSION

Prior to 1994 the principles relating to informed consent were largely established through the common law. As stated earlier, these principles made it clear that patient autonomy must be respected. Post-1994 we have seen many of the principles codified in various laws such as the Constitution of the Republic of South Africa which is the supreme law of the Republic[239], the National Health Act[240], The Mental Health Care Act[241], Choice on Termination of Pregnancy Act[242], Sterilization Act[243], and the Children's Act[244]. It has been argued that a key strength of our framework is that the Constitution provides clear provisions with regards to an individual's bodily and psychological integrity, whereby such integrity can only be interfered with, based on the doctrine of *volenti non fit injuria.*[245] These provisions are contained in Section 12 (2)(a)-(c) highlights these rights.[246]

Badul *et al* submit that although the Sterilization Act is silent as to who ought to obtain informed consent from the patient wishing to be sterilized, the court in Pandie[247] case erred in suggesting that a surgeon may delegate this task to a nurse[248]. In **Janse Van Vuuren and Another NNO v Kruger**[249] the then Appellate Division, when dealing with an HIV positive patient's right to confidentiality, held that patients have a right to expect that their medical practitioner complies with the professional guidelines.[250] Given that the ethical guidelines require the surgeon to take responsibility for obtaining consent, regardless of whether they

---

[239] Section 2 of the Constitution of the Republic of South Africa 1996.
[240] Act 61 of 2003
[241] Act 17 of 2002
[242] Act 92 of 1996
[243] Act 44 of 1998
[244] Act 38 of 2005
[245] A. Barit , 'Doctrine of Informed Consent in South African Medical Law'(LLM Thesis University of Pretoria 2017) at page 9.
[246] Section 12(2) of the Constitution of the Republic of South Africa 1996 provides that:
(2) Everyone has the right to bodily and psychological integrity, which includes the right-

a) To make decisions concerning reproduction;
b) To security in and control over their body;
c) Not to be subjected to medical or scientific experiments without their informed consent.

[247]Pandie v Isaacs [2013] ZA WCHC123.
[248] C.J Badul, A. Strode, Singh. 'Obtaining Informed consent for sterilisation in the light of recent case law' (2018) South African Medical Journal 108(7):557-558 at page 558.
[249] 1993 ZA SCA 1450.
[250] C.J Badul, A. Strode, Singh. 'Obtaining Informed consent for sterilisation in the light of recent case law' (2018) South African Medical Journal 108(7):557-558 at page 558.

delegate part of this task, it was inappropriate of the court to suggest that liability could potentially be placed at the feet of the nurse.[251] Secondly, in defending a civil claim, a surgeon is able to rely on the defence of *volenti non fit injuria.[252]* It would, however, be very difficult for them to prove all elements of the defence if they did not themselves obtain informed consent.[253] Thirdly, the court only gave one rationale for the nurse rather than the surgeon being responsible for obtaining consent, that is, because it was accepted practice within the profession.[254] Fourthly, the complexity of transferring the task of consent obligation to a nurse would be: which nurse would be liable?; there may be several nurses who are involved in the consent process such as the ward and theatre nurses.[255] The above writers submit that despite the Sterilisation Act being silent on who has the obligation of obtaining consent from a patient for the sterilisation procedure, there is an express duty on the surgeon, given the Health Professions Council Guidelines.[256]

In **Paddie v Isaacs**[257]the brief facts were that the plaintiff Isaacs was married to Prinsloo going through a divorce when she found out she was pregnant with her fourth child. She attended ante-natal classes with her gynaecologists when the question of sterilization was raised. Outright she indicated that she did not want to be sterilised. According to her doctor it was standard to raise the issue considering the birth would be her third caesarean. According to Isaacs she was given a note to deliver to the attending doctor in hospital when she went to give birth. Unbeknown to her, her gynaecologists had written caesarean and tubular ligation. She was given consent form before her caesarean which she refused to sign saying the nurses must remove the tubular ligation part as she had no intention of getting sterilized. According to the defendant when he arrived at theatre the table and tools for the performance of caesarean and tubular ligation were laid out for him; he further confirmed with the nurse Venter that Isaacs was going to be sterilized after caesarean. The nurse was unavailable to testify at trial as she had since passed away, and according to the doctor she had confirmed Isaacs surgery. The court remarked as follows:

[251] *Ibid* at page 558
[252] *Ibid* at page 558
[253] *Ibid* at page 558
[254] *Ibid* at page 558
[255] *Ibid* at page 558
[256] *Ibid* at page 558
[257] [2013] ZAWCHC 123.

"I have already expressed a view that a lawful consent to sterilization must be in writing as required by the Sterilization Act 44/1998. No written consent was obtained in this case. The prima facie conclusion that the performance of the sterilization was wrongful was not negative by consent as required by law".

This, the court based on the factual finding that even though the plaintiff had given consent, she had changed her mind and communicated the change to the nurses who failed to convey same to the defendant. It was one of the duties of the medical personnel to inform the plaintiff of her right to change her mind in terms of section 4(c) of the Sterilisation Act. Nevertheless, obtaining written consent was, in practise, the function of the nurse and Dr Pandie could not be held liable for negligence for failing to confirm the contents of the consent document with Isaacs. The court further held that in the event of the patient changing her mind, there would be a duty on the nurse to bring this to the attention of the gynaecologist. In coming to this conclusion, the court relied on expert evidence that is was not a common practice among surgeons to personally check written consent forms before operating.

3.1.1 Strengths of legislation dealing with consent to medical treatment

The strength of the legislation guiding consent to medical treatment can be found in the various Acts promulgated to protect patients. One of the strengths is that the National Health Act provides for the patient's right to self-determination and the requirement of informed consent to medical treatment in Section 7 (1)(a)-(e)[258]. In addition the Act sets out the nature and scope of the information that should be disclosed.[259] Shared decision-making has become more prominent; partly because there is an ethical imperative to involve patients properly in decisions about their care, and partly because there is increasing evidence that this approach have benefits.[260] Even if the practitioner does not believe that the decision is in the patient's best interests, provided it is reached after full consideration of the available options and is therefore an informed decision, the patient is entitled to fulfil his/her right to self-

[258] Section 7 (1)(a)-(e) of The National Health Act 61 of 2003 sets out the requirements of informed consent, who must consent where the patient is not in a position to so do.

[259] H. Manyonga *et al* 'From Informed Consent to Shared Decision-making' (2014) South African Medical Journal Vol. 104 (8): 561-562 at page 561.

[260] G. Elwyn *et al.*' Implementing Shared Decision-Making in the NHS' (2010) BMJ https://doi.org/10.1136/bmj.c5146 accessed on 15 August 2021

determination.[261] This is so because the law requires the medical practitioner to adhere to the provisions of Section 7 of the National Health Act to ensure that the patient has given informed consent.

Importantly, there is a very nuanced approach in South Africa as valid consent to medical treatment requires knowledge not only of the general nature of medical treatment but also knowledge of the consequences of the treatment and; in determining which consequences should be disclosed to the patient, the constitutional rights to equality and self-determination support the application of a subjective patient-centred test for informed consent.[262] However the law seems to focus on patients' right to self-determination as that is embodied in section 12 of the Constitution.[263] The best interests of the patient are sometimes considered when the patient lacks decisional capacity; this is so as to avoid death or prevention of irreversible damage to the patient's health[264] In deciding what options may be reasonable considered as being in the best interests of a patient who lacks capacity to consent to treatment health care practitioners should take into account[265]:

a) The options for investigation of treatment which are clinically indicated[266]
b) Any evidence of the patient's previously expressed preferences, including an advanced statement[267]
c) Their own and the health care team's knowledge of the patient's background, such as cultural, religious or employment considerations[268]
d) Which option least restricts the patient's future choices, where more than one option (including non-treatment) seems reasonable in the patient's best interests[269]

[261] H. Manyonga *et al* 'From Informed Consent to Shared Decision-making' (2014) South African Medical Journal Vol. 104 (8): 561-562 at page 561.
[262] M.C Wilson. 'Assault in Medical Law: revisiting the boundaries of informed consent to medical treatment in South Africa' (2009) Journal Law Med 16(5): 862-84 at page 862.
[263] Section 12 of the Constitution of the Republic of South Africa 1996
[264] Consent to Medical Treatment in South Africa-An MPS Guide (2010) Medical Protection Society at page 10 www.medical protection.org accessed on 06 June 2022
[265] HPCSA (2008) Seeking Patient's Informed Consent: The Ethical Considerations at paragraph 10
[266] *Ibid* at paragraph 10
[267] *Ibid* at paragraph 10
[268] *Ibid* at paragraph 10
[269] *Ibid* at paragraph 10

e) Views about the patient's preferences given by a third party who may have other knowledge of the patient, for example the patient's partner, family, carer, or a person with parental responsibility[270]

MacQuoid-Mason interprets section 7 as providing a possible mechanism for overcoming the common law problem of enduring powers of attorney becoming invalid if patients become mentally incompetent. Any treatment that is authorised by law or a court order or is necessary to protect public health may lawfully be carried out under the terms of the Act. The National Health Act also allows for emergency medical treatment to prevent either death or irreversible damage to the patient's health, provided the patient had not "expressly, impliedly or by conduct" refused such treatment. This is provided for in Section 7(1)(e) of the National Health Act. If the patient is found to be lacking decisional capacity to make an informed consent about the proposed treatment it may be possible to wait until the patient has gained decisional capacity, but if this is not an option, medical intervention may proceed with the consent of someone the law recognises as an acceptable proxy.

3.1.2 Complexities

Complexities include amongst others obtaining consent from children. However, research indicates that children older than 14 years have thought process similar to those of adults.[271] Jean Piaget determined that children between ages of 7 and 11 years were in the concrete operational stage, during which they acquire the concept of conservation, but cannot reason abstractly or test hypothesis systematically.[272] From age 11 children start to think abstractly, reason logically and draw conclusions from the information available, as well as apply these processes to hypothetical situation.[273] There is no gold standard test to determine competency in children.[274] Of concern is that children are particularly vulnerable in the healthcare decision-making because they want to please parents, peers and medical staff thereby basing decisions on perceived hopes rather than facts.[275]

---

[270] *Ibid* at paragraph 10

[271] V. Miller *et al* 'Children's competence for assent and consent: A review of empirical findings. Ethics Behaviour' (2004) Pubmed 14(3): 255-295 at page 255.

[272] F. Power *et al*. 'Approach to Moral Education and the moral atmosphere of the school' (2008) researchgate.net/publication 288869148-. accessed 09 August 2021

[273] *Ibid*

[274] J Van Heerden *Et Al.* 'Children's ability to consent to medical management in South Africa' (2020) South African Journal for Child Health 14(1): 25-29 at page 25.

[275] E. Kodish. 'Informed consent for Paediatric research; Is it really possible?' (2003) Journal of Paediatrics 142(2) 89-90 at page 89.

A 2020 study by J Van Heerden[276] confirmed that children 12 years and older were capable of giving informed consent to medical procedures as they were able to choose the treatment, understand the information, deliberate the outcome, and provide rational reasons for their choice in concrete concepts.[277] The study also proved that children possessed reasoning skills and actual understanding of complex abstract concepts, although not completely similar to those of adults.[278] The study concluded that children of 12 years and older are able to choose a treatment option and possess the necessary reasoning skills to deliberate their choice.[279] However, only children above 14 years possess actual understanding when dealing with more abstract concepts such as depression.[280] It is clear therefore that the law and our under-standing of children's capacity to make medical treatment decisions are in sync as only children over the age of 12 who are capable of making the decision have capacity. Van Heerden, in his study also concluded that "It stands to reason that basic choices regarding the administration of medicine and minor surgical interventions are in the abilities of decision-making for younger children, but that psychiatric treatments and interventions with severe consequences are outside the scope of younger children's abilities.[281]

The Choice of Termination of pregnancy Act provides the provision of consent of pregnant women for termination of pregnancy regardless of their age.[282]Section 2 of the Choice of Termination pf pregnancy Act provides circumstances in which and conditions under which pregnancy may be terminated.[283] These are enunciated as follows:

Section 2 (1) A pregnancy may be terminated –

a) Upon request of a woman during the first 12 weeks of the gestation period of her pregnancy;
b) From the 13th up to and including the 20th week of the gestation period if a medical practitioner, after consultation with the pregnant woman, is of the opinion that –

[276]J Van Heerden *Et Al.* 'Children's ability to consent to medical management in South Africa' (2020) South African Journal for Child Health 14(1): 25-29 at page 28.
[277] *Ibid* at page 28
[278] *Ibid* at page 28
[279] *Ibid* at page 28
[280] *Ibid* at page 28
[281] *Ibid* at page 28
[282] Ramprakash Kaswa & Parimalaranie Yogeswaran 'Abortion reforms in South Africa: An overview of the Choice of Termination of Pregnancy Act' (2020) AOSIS publisher. South African Family Practice at page 3 of 5
[283] Section 2 (1) and 2 of the Choice of Termination of Pregnancy Act No.92 of 1996

i. The continued pregnancy would pose a risk of injury to the woman’s physical or mental health;
ii. There exist a substantial risk that the foetus would suffer from a severe physical or mental abnormality; or
iii. The pregnancy resulted from rape or incest; or
iv. The continued pregnancy would significantly affect the social or economic circumstances of the woman; or

(c) After the 20th week of the gestation period if the medical practitioner, after consultation with another medical practitioner or a registered midwife, is of the opinion that the continued pregnancy –

i. Would endanger the woman’s life;
ii. Would result in a severe malformation of the foetus; or
iii. Would pose a risk of injury to the foetus.[284]

Despite the liberalisation of the abortion law and the relative availability of abortion facilities, access to legal abortion services remains a major challenge for many women in South Africa.[285]As a result of this there is a high number of illegal abortions performed outside the designated legal facilities.[286]This high number of illegal abortions highlighted that legalisation alone cannot ensure sexual and reproductive health freedom.[287]A lack of knowledge regarding abortion rights under the Choice Act and the perceived poor quality of reproductive health facilities are the other important barriers to access termination of pregnancy services.[288] The lack of knowledge of the time-limited nature of termination of pregnancy services amongst healthcare users and providers forced the disgruntled users to seek help outside the established legal system.[289]

---

284 Section 2(1) of the Choice of Termination of Pregnancy Act No.92 of 1996

285 Ramprakash Kaswa & Parimalaranie Yogeswaran ‘Abortion reforms in South Africa: An overview of the Choice of Termination of Pregnancy Act’ (2020) AOSIS publisher. South African Family Practice at page 4 of 5

286 *Ibid* at page 4

287 *Ibid* at page 4

288 *Ibid* at page 4

289 *Ibid* at page 4

3.1.3 Weaknesses

Weaknesses are there is sometimes limited respect for the law. A good example of this is research into the coerced or forced sterilisation of women living with HIV. The ethical principle of autonomy literally means "self-rule".[290] It refers to the right of every individual to make decisions for himself or herself.[291] In healthcare this would entail allowing the patient to make the final decision regarding his or her treatment after being provided with all the necessary and relevant information.[292] This principle cannot be used for persons who are not autonomous as a result of being immature, incapacitated, ignorant, coerced into a decision or exploited.[293] This means that for autonomy to exist capacity has to exist as well.

Even though the ethical-legal framework for consent to medical treatment and surgery is well established, one of the unresolved complexities is the question of who bears the legal duty to obtain the consent to ensure that consent has been obtained for sterilisation.[294] This is a broad issue involving the potential liability of a surgeon for failing to personally obtain and record the consent of a patient, and it has come before the courts in relation to two sterilisation cases.[295] The Act specifies that consent must be free from coercion and must be provided after an unambiguous explanation of the proposed procedure, including information of its permanency or reversibility.[296] This legislative framework promotes and protects patient autonomy and the rights to bodily and psychological integrity, including the right to make reproductive decisions.[297] It also safeguards the right to dignity[298] to the extent that the Act ensures that sterilisation decisions are made in an environment of accountability and respect. [299]

---

[290] K. Moodley; Medical Ethics, Law and Human Rights; 2nd Edition 2017 at page 54.
[291] *Ibid* at page 54
[292] *Ibid* at page 54
[293] *Ibid* at page 54
[294] C.J Badul *et al*. 'Obtaining informed consent for sterilisation in light of the recent case law' (2018) South African Medical Journal 108 (7) 557-558 at page 558.
[295] Pandie v Isaacs (2013) ZA WCHC 123.
[296] *Ibid.*
[297] C. Pickels. 'Involuntary Contraceptive sterilisation of women in South Africa and the criminal law' (2016) South African Journal of Criminal Justice 89-115 at page 92.
[298] Section 10 of the Constitution of the Republic of South Africa 1996.
[299] C. Pickels. 'Involuntary Contraceptive sterilisation of women in South Africa and the criminal law' (2016) South African Journal of Criminal Justice 89-115 at page 92.

There is no dicta pertaining to the involuntary sterilization of HIV positive women in South Africa, despite evidence[300] of several women having undergone the procedure without consent; consequently reference will be made to the judgment of Namibia cited as **LM and Others v Government of Namibia.**[301] The brief facts were that the three plaintiffs were all HIV positive women, who alleged that they had been sterilised without their informed consent.[302] They further alleged that they had been sterilized because they are HIV positive.[303] The first plaintiff testified to have signed a single consent form for both caesarean and tubular ligation; at the time she had been in labour for 14 to 15 hours. She testified that she was informed by a nurse that she would be sterilised since all HIV positive women go through that procedure.[304] Second plaintiff signed the same form, hers indicated that she was consenting to caesarean and tubular ligation based on a previous caesar. The third plaintiff also signed a consent to caesarean and tubular ligation after prolonged labour, she signed the forms while on a stretcher going to theatre.[305] In summary all three plaintiffs were sterilized immediately after or during a caesarean section.[306] They all had children from previous pregnancies; one plaintiff was under the age of 30; they signed consent forms while in active labour, and immediately prior to the birth of their children.[307] Two civil claims were instituted (a) a claim for damages grounded on civil law, that the surgical procedures were unlawful as they were performed without the plaintiffs' consent, or alternatively that they were unlawful as the medical practitioners had breached their duty of care that they owed to the three plaintiffs[308] ; (b) a claim based on the Constitution of the Republic of Namibia, that the sterilizations were done as part of a wrongful and discriminatory practise of discrimination based on the women's HIV status. This amounted to a breach of their basic human rights, as guaranteed by the Constitution.[309] The Namibian government raised the defence of *volenti not fit injuria* arguing that all three plaintiffs had

---

[300] A. Strode, S. Mthembu, Z. Esaack 'She made up a choice for me': 2 HIV positive Women's Experiences of Involuntary Sterilisation in Two South African Provinces' (2012), Reproductive Health Matters, Vol.20 (39): 61-69 at page 61.
[301] Case no.1603 of 2008.
[302] C. J Badul, A. Strode. 'LM & Others v Government of the Republic of Namibia: The first sub-Saharan African case dealing with coerced sterilizations of HIV positive women Quo Vadis?' (2013) African Human Rights Law Journal; AHRLJ 214-228.
[303] ML and Others v Government of Namibia case no.1603 of 2008 at paragraph 2.
[304] *Ibid* at paragraph 16.
[305] *Ibid* at page 25.
[306] C. J Badul, A. Strode. 'LM & Others v Government of the Republic of Namibia: The first sub-Saharan African case dealing with coerced sterilizations of HIV positive women Quo Vadis?' (2013), African Human Rights Law Journal 2013 AHRLJ 214-228.
[307] *Ibid* at page 218.
[308] *Ibid* at page 219.
[309] *Ibid* at page 220.

signed consent forms indicating that they had agreed to the sterilization.[310] The court held that any consent provided must be given freely and voluntarily and should not have been induced by fear, fraud or force. As earlier expressed, the three plaintiffs had signed the required consent forms while in active labour.[311] The court held that consent should not be obtained in these circumstances – not only because it impacted voluntariness, also because it made the consent process hurried.[312] With regard to the second claim that the plaintiffs were unfairly discriminated against, this was summarily dismissed by the judge on the basis that there was no credible and convincing evidence that the sterilization procedures had been performed on them simply because they were HIV positive.[313]

The weaknesses of the framework are firstly that, although the Children's Act allows caregivers to consent to medical treatment, they do not have the authority to consent to surgery on a child in their care.[314] This disadvantages children who are not living with their parents.[315] Secondly, the law does not specify who must obtain the consent for an operation, and this has led to disputes.[316] Courts have noted that it is common practice for this function to be delegated to a nurse, even though the Health Professions Council of South Africa Guidelines for Good Practice in the Health Care Professions Seeking Patient's Informed Consent: The Ethical Considerations requires surgeons to take final responsibility for ensuring that consent has been properly obtained.[317][318]

[310] *Ibid* at page 220.
[311] *Ibid* at page 222.
[312] LM and Others v Government of Namibia case no.1603 of 2008 at paragraph 60.
[313] *Ibid* at paragraph 82.
[314] A. Strode, C.J Badul. 'Forms to capture child consent to surgical procedures: Time to focus on function rather than form' (2021) South African Journal of Bioethics and the Law 14(1):20-23 at page 23.
[315] *Ibid* at page 23
[316] *Ibid* at page 23
[317] *Ibid* at page 23
[318] Health Professions Council of South Africa. 'Guidelines for good practice in the health care professions. Seeking patient's informed consent: the ethical consideration' (2016) Booklet 4 pages 86-103 at page 90.

CHAPTER FOUR

4.1 CONCLUSIONS AND RECOMMENDATIONS

In this chapter the research questions mentioned in Chapter one shall be answered in order to determine if the South African Legal Framework is designed to protect patients or is it a mechanism of providing doctors a justification for some or other illegal act in the course of medical treatment and surgical operations.

(i) Is there a positive right to consent or is consent simply a defence which may be used to justify an otherwise unlawful conduct?

In recent times, advocates of shared and informed healthcare decision-making have also demonstrated that consent to medical treatment promotes patient comprehension and autonomy, reduces unwanted medical procedures and malpractice claims, improves patient compliance to treatment[319] and decreases overall costs of health service delivery.[320] Therefore, if practiced properly consent to medical treatment and shared healthcare decision-making can become valuable tools in preventative medicine which is sorely needed in South Africa and other developing countries.[321] Consequently consent is a positive right, that enjoys protection from the Law through legislation, starting from the Constitution of the Republic of South Africa, 1996, Chapter two thereof; to the pieces of legislation which parliament thought prudent to enact to protect patients.

(ii) Has there been a shift to recognition of consent to medical treatment being a positive right through various post-1994 pieces of legislation?

Section 27 of the Constitution gives everyone the right to access healthcare services including reproductive health care[322] and imposes an obligation on the state to ensure the rights in section

---

[319] G. Flores 'Language barriers to healthcare in the United States' (2006) New England Journal of Medicine 355: 229-331 at page 229.

[320] R.M Kaplan 'Shared medical decision making: a new tool for preventive medicine (2004) American Journal of Preventive Medicine 26: 81-83 at page 81.

[321] S.C Chima 'An Investigation of Informed Consent in clinical practice in South Africa' (PhD Thesis University of South Africa 2018) at page 484.

[322] Section 27(1)(a) of the Constitution of the Republic of South Africa 1996.

27 are realized[323]; further it guarantees that no one may be refused emergency medical treatment.[324] The National Health Act contains various sections enforcing that consent for any medical treatment is a right that deserves protection; especially when one reads the Act in conjunction to the protected rights in the Constitution, Bill of Rights. Section 5 of the National Health Act provides that "A healthcare provider, health worker or health establishment may not refuse a person emergency medical treatment".[325] This is in line with the provisions of Section 27(3) of the Constitution of the Republic of South Africa 1996. Section 6 makes for provision for full disclosure to a patient before any proposed medical treatment is to be given. This full disclosure requirement has been tested through the courts and it has become now settled law that the standard test for full disclosure is that of a disclosure of material risk inherent with the procedure or treatment that must be disclosed to a patient. Children are also protected by the provisions of the Children's Act, section 129 dealing with consent to medical treatment and surgical operations and Section 130 dealing with consent to HIV testing. These are some of the pieces of legislation that guarantee protection of individuals from treatment and operations without consent.

(iii) Does the current law protect patient rights to autonomy?

It has now become settled law that a doctor is obliged to warn the patient about any "material risks" inherent in the propose treatment.[326] A risk is regarded as "material" if (a) a reasonable person in the position of the patient would, when warned of the risk, attach significance to it; and (b) a medical practitioner is reasonable aware that the patient, if warned of the risk, would attach significance to it.[327] There is no duty to warn a patient about all conceivable complications that may arise in a procedure.[328] However, the doctor should, at a minimum, inform the patient about the more serious risks involved.[329]

This study reveals that the regulatory framework of consent to medical treatment practice in South Africa is robust, based on the legal requirements of the National Health Act 63 of 2003

[323] Section 27(2) of the Constitution of the Republic of South Africa 1996.
[324] Section 27(3) of the Constitution of the Republic of South Africa 1996.
[325] Section 5 of the National Health Act 61 of 2003.
[326] Moodley K. *Medical Ethics, Law and Human Rights* 2nd Edition (2017) at page 138.
[327] *Ibid* at page 138
[328] *Ibid* at page 138
[329] *Ibid* at page 138

and the principles laid down in the Constitution of the Republic of South Africa 1996 and the Bill of Rights.[330] This is further supported by some common law judgments, especially the landmark judgment of the full bench of the Cape High Court in the Castell case[331],[332], which arguably adopted "prudent patient" and "material risks" standard of information disclosure during consent to medical treatment into South African legal jurisprudence.[333] Unfortunately, recent judgments by the Supreme Court of Appeal in the Oldwage case[334] and **Sibisi NO v Maitlin**[335] appear to show the SCA vacillating between the reasonable doctor standard as applied in the case of **Richter v Estate Hamman**[336] and the prudent patient standard as established in the Castell case.[337]

It has been argued that the provisions of the Constitution relating to the rights to bodily and psychological integrity, as well as the right to security and control over one's body, as stipulated in Section 12(2) of the Constitution of the Republic of South Africa 1996 have not been fully addressed or implemented in recent judgments by the SCA and other South African Court judgments.[338] In addition, the applicable legislative requirements as adumbrated in sections 6 to 8 of the National Health Act are not being implemented by South African Courts[339] as illustrated in the **Sibisi NO v Maitlin**[340] and **Pane v MEC Free State.**[341] South African courts also appear to have introduced a secondary standard of proof in consent cases, which may now impose on aggrieved plaintiffs a dual burden[342] whereby a claimant, or plaintiff needs to prove both negligence, as well as lack of informed consent to medical treatment to succeed

---

[330] S.C Chima 'An Investigation of Informed Consent in clinical practice in South Africa' (PhD Thesis University of South Africa 2018) at page 484.
[331] *Ibid* at page 484
[332] Castell v De Greef 1994 (4) SA 408 (C).
[333] P.A Carstens and D. Pearmain *Foundational Principles of South African Medical Law,* Lexis Nexis Publishers (2007) at page 681.

[334] Louwrens V Oldwage (2004) 1 All SA 532 (C).
[335] (2014) ZASCA 156.
[336] 1976 (3) SA 226 (C).
[337] S.C Chima 'An Investigation of Informed Consent in clinical practice in South Africa' (PhD Thesis University of South Africa 2018) at page 486.
[338] P.A Carstens and D. Pearmain *Foundational Principles of South African Medical Law*, Lexis Nexis Publishers (2007) at page 686 see also R. Britz and A. Roux-Kemp 'Voluntary Informed Consent and good clinical practice for clinical research in South Africa: Ethical and Legal Perspectives (2012) South African Medical Journal Vol102 (9): 746-748 at page 746.
[339] *Ibid* at page 746
[340] (2014) ZASCA 156
[341] 2016 ZAFSHC 99.
[342] Zwart (2015) *De Rebus* 33.

in informed consent cases.[343] In both cases mentioned above, the plaintiffs lost their claims for damages regarding failure to obtain informed consent by doctors, when the courts concerned ruled that once the claimant is unable to prove negligence, then the claim for lack of informed consent automatically falls away or becomes moot.[344]

In light of the above contradictory and conflicting judgments by South African courts, a need arises to re-evaluate consent to medical treatment by the constitutional court, based on public policy considerations, with a view to clearly define the standard of information disclosure to be followed by South African courts, in cases of failure to obtain valid informed consent for medical treatment.[345] This needs to be done in the context of constitutional obligations to respect and enhance human dignity, as stipulated in section 10 of the Bill of Rights, as well as the individual's rights to bodily and psychological integrity as stipulated in section 12 of the Constitution of the Republic of South Africa 1996.[346]

4.2 RECOMMENDATIONS

One recommendation I submit is for the employment of interpreters within the health care sector. More often than not, when a patient is scheduled for an operation or treatment the medical practitioner who is tasked with obtaining informed consent for such treatment or surgery is someone who does not speak the language of the patient. The nurses are also unable to explain the intricacies of the procedure with such detail so as to obtain an informed consent from the patient.

Secondly, further training of health care professionals into the legalities of obtaining informed consent for treatment or surgery is needed. From this study and the review of literature it was established that most healthcare practitioners have no knowledge of consent laws; they do not know the consent laws in the Children's Act of 2005 and are therefore unable to apply such

[343] S.C Chima 'An Investigation of Informed Consent in clinical practice in South Africa' (PhD Thesis University of South Africa 2018) at page 487.
[344] *Ibid* at page 487
[345] S.C Chima. 'An Investigation of Informed Consent in clinical practice in South Africa' (PhD Thesis University of South Africa 2018) at page 488.
[346] *Ibid* at page 488

laws into their everyday dealings with children in a hospital setting. Therefore continued professional development of healthcare practitioners in the areas of medical law, bioethics and human rights, especially by introducing courses in bioethics and medical law into nursing schools curricular, where they do not exist, would be beneficial.[347]

[347] *Ibid* at page 488

BIBLIOGRAPHY

Appelbaum PS Clinical Practise *Assessment of patient's competence to consent to treatment* (2007) Google Scholar 375 (18): 1834-1840

Badul CJ, Strode A. LM & Others v Government of Namibia: The first Sub-Saharan Africa case dealing with coerced sterilization of HIV-positive women – quo vadis? (2013) African Human Rights Journal 214-228

Badul CJ et al *Obtaining informed consent for sterilization in light of the recent case law* (2018) South African Medical Journal 108 (7) 557-558

Bolton D *Informed Consent* (2012) South African Orthopaedic Journal 108

Buchner-Eveleigh M *Is it a competent child's prerogative to refuse medical treatment?* De Jure Law Journal Vol 52 242-256

Chima SC "*Because I want to be informed, to be part of the decision-making": Patients insights on informed consent practices by healthcare professionals in South Africa* (2015) Nigerian Journal of Clinical Practice S46-56

Chima SC (2013). Evaluating the quality of informed consent and contemporary clinical practices by medical doctors in South Africa: An empirical study. *BMC Medical Ethics* 14 S1-S3

Chima SC (2017). Understanding and Practice of Informed Consent by Professional Nurses in South Africa: An Empirical Study-Brief Report.

Consent to medical treatment in South Africa; An MPS Guide (2010) 3

CW Van Staden, C Kruger *Incapacity to give consent owing to mental disorder* (2003) Journal of Medical Ethics 29(1) 41-43

DW Jordan H*uman dignity and the future of the voluntary active euthanasia debate in South Africa* (2017) South African Medical Journal 107 (5) 383-385

Dain Van der Reyden *The right to respect for autonomy* (2008) South African Journal of Occupational Therapy Volume 38 Number 1

Davidson L (2017) Capacity to consent to or refuse psychiatric treatment: an analysis of South African and UK law. *South African Journal on Human Rights* 32 (3) 457-489

Du Toit M (2018). Involuntary sterilization of HIV-positive women in South Africa: A current legal perspective. *South African Journal of Bioethics law* 11 (2) 80-84

Elwyn G et al *Implementing shared decision-making in the NHS* (2010) BMJ 341:c5146

Flores (2006) N Engl J Med 229-331

W Ganya, S Kling and K Moodley (2016). Autonomy of the child in the South African Context: is a 12 year old of sufficient maturity to consent to medical treatment. *BMC Medical Ethics* 17: 66

Hogan Lovells *An informed patient is a happy patient* (2014)

Health Professions Council of South Africa *Guidelines for good practice in the healthcare professions: seeking patient's informed consent: the ethical considerations* (2016)

Hein et al *Why is it hard to make progress in assessing children's decision-making competence* (2015) BMC Medical Ethics 16:1

Kaplan (2004) Am J Prev Med 81-83

Kayode S Aderibigbe and Sylvester Chima *Knowledge and practice of informed consent by physiotherapists and therapy assistance in Kwazulu-Natal province, South Africa* (2019) South African Journal of Physiotherapy 75(1): 1330

Kodish E *Informed consent for Paediatric research; Is it really possible?* (2003) Journal of Paediatrics 142(2) 89-90

A Mamoojee, A. Alli (2018). Anaesthetist's knowledge of South African Law pertaining to informed consent. *South African Journal of Anaesthesia and Analgesia.*24 (6) 155-164

Manyonga H et al *From Informed consent to shared decision-making* (2014) South African Medical Journal Vol. 104 No.8

More et al *Medical information therapy and medical malpractice litigation in South Africa* (2013)

Miller V et al *Children's competence for assent and consent: A review of empirical findings* (2004) Ethics behaviour 14(3): 255-295

McQuoid-Mason, Mahomed Dada *The National Health Act: some implications for family practice* (2006) CME Vol.24 No.1

McQuoid-Mason *Parental refusal of blood transfusions for minor children solely on religious grounds – the doctor's dilemma resolve* (2005) South African Medical Journal Vol.95 No.1

McQuoid-Mason *Advanced directives and the National Health Act* (2006) South African Medical Journal 1236-1237

McQuoid-Mason *Provisions for consent by children to medical treatment and surgical operations, and duties to report child and aged persons abuse* (2010) South African Medical Journal 100 (10) 646-648

McQuoid-Mason *Termination of pregnancy in children: Consent and confidentiality issues* (2010) South African Medical Journal Vol 100 No.1

McQuoid-Mason *Michael Jackson and the limits of patient autonomy* (2012) South African Journal of Bioethics and Law 11

McQuoid-Mason *Emergency medical treatment and 'do not resuscitate' orders: When can they be used* (2013) South African Medical Journal 103 (4): 223-225

McQuoid-Mason *Can children 12 years or more refuse life-saving treatment without consent or assistance from anyone else?* (2014) South African Medical Journal 104(7): 446-467

McQuoid-Mason *Parents refusing blood transfusions for their children solely on religious grounds: Who must apply for the court order?* South African Medical Journal 110 (2): 100-101

Moosa MYH, Jeena FY *Involuntary treatment of psychiatric patients in South Africa* (2008) African Journal of Psychiatry 11:109-112

Naidu S, Gopalan PD *The perspectives of eThekwini public service anaesthetic doctors on the informed consent process for anaesthesia* South African Journal of Anaesthesia and Analgesia 19:2 96-101

Nienaber A *The right to physical integrity and informed refusal: Just how far does a patient's right to refuse medical treatment go?* (2016) South African Journal of Bioethics and Law Vol. 9 73-77

Ngene NC, Bodiba T *Challenges in obtaining consent for caesarean delivery in minors in South Africa* (2020) South African Journal of Obstetrics Gynaecologists 26(1): 38-41

Power F et al *Approach to moral education* (1989) Columbia University Press

Pickels C *Termination of pregnancy rights and foetal interests in continued existence in South Africa: The choice of termination of Pregnancy Act 92 of 1996* (2012) PER/PELJ 15 (5)

Pickels C *Involuntary contraceptive sterilization of women in South Africa and the criminal law* (2016) South African Journal of Criminal Justice 89-115

Ramprakash Kaswa, Parimalaranie Yogeswaran *Abortion reforms in South Africa: An overview of the Choice of Termination of Pregnancy Act* (2020) AOSIS publisher. South African Family Practice

Retha Britz, Andra le Roux-Kemp (2012). Voluntary informed consent and good clinical practice for clinical research in South Africa: Ethical and legal perspectives. *The South African Medical Journal* 102 (9) 746-748

SAMA *Guidelines on Informed Consent* (2012)

Singh JA et al *XDR-TB in South Africa: No time for denial or complacency* (2007) Plos Med 4(1): e50

Snow HA, Fleming BR *Consent, capacity and the right to say no.* (2014) South African Medical Journal 201(8): 486-488

Strode A et al *'She made up a choice for me': 2 HIV positive women's experiences of involuntary sterilization in two South African provinces* (2012) Reproductive health matters Vol 20 No.39 27-38

Strode, Badul (2021) *Forms to capture child consent to surgical procedures: Time to focus on function rather than form* South African Journal of Bioethics and the Law 14(1):20-23 SAJBL.2021.v14i1.696

Turell SL et al *Consent to treatment in adolescents with anorexia nervosa* (2011) International Journal of Eating Disorders 44:8 703-707

Van de Westhuizen *Medical treatment v Surgery: where does medical treatment ends and surgery begin in terms of section 129 of the Children's Act?* Sabinet 39 (3) 791-802

Van Staden CW, C Kruger (2003). Incapacity to give consent owing to mental disorder. *Journal of Medical Ethics* 29 (1) 41-43

Van de Westhuizen C (2018). Medical treatment v surgery: where does medical treatment ends and surgery begin in terms of section 129 of the Children's Act? *Sabinet* 39 (3) 791-802

Van Heerden et al *Children's ability to consent to medical management in South Africa* (2020) South African Journal for Child Health 14(1): 25-29

Van Loggerenberg A *An alternative approach to informed consent* (2018) South African Law Journal Vol. 135 No.1 55-72 HeinOnline

Vemuri M *Ethical consideration in treating women with mental illness during pregnancy* (2012) The Journal of Lifelong Learning in Psychiatry Vol. X No.1

Wilson MC *Assault in Medical Law: revisiting the boundaries of informed consent to medical treatment in South Africa* (2009) Journal of Medical Law 16(5): 862-84

Zalpuri I et al *Decision capacity in pregnancy: A complex case of pregnancy termination Psychosomatics* (2015) 56(3): 292-297

Zwart L *Sibisi NO v Maitin: A dual burden of proof?* (2015) *De Rebus* 33

TABLE OF CASES

AB and Another v Minister of Social Development (CCT155/15) [2016] ZACC 43

Beukes v Smith [2019] ZASCA 48

Castell v De Greef 1994 (4) SA 408 (CC)

Christian Lawyers Association v Minister of Health 2005 (2) SA 509 (T)

Dawood and Another v Minister of Home Affairs and Others (CCT35/99) [2000] ZACC 8

Hattingh v Roux 2011 (5) SA (WCC) 141

Hay v B 2003 (3) SA 492 (W)

Janse Van Vuuren NNO v Kruger 1993 ZA SCA 1450

Khumalo and Others v Holomisa (CCT53/01) [2002] ZACC 12

Life Healthcare Group (PTY) Ltd & Another v JMS (as parent and guardian of the infant child TM) and Another [2014] ZAGP JHC 299

Louwrens v Oldwage 2004 1 ALL SA 532

Lymbery v Jeferries 1925 AD 236

Masethla v President of the Republic of South Africa 2008 (1) SA 566 (CC)

McDonald v Wroe 2006 (30 ALL SA 565 (C)

Minister of Health v Goliath 2009 (2) SA 248 (C)

Minister of Safety & Security v Gaqa [2002] ZAWCHC 9

Minister of Safety & Security v Xaba 2004 (1) SACR 149 (D)

Pandie v Isaacs [2013] ZAWCHC 123

Pane v MEC Free State [2016] ZAFSHC 99

Richter and Another v Estate Hammann 1967 (3) SA 226 (C)

Santam Insurance v Vorster 1973 (4) SA 764

Sibisi NO v Maitin [2014] ZASCA 156

Stoffberg v Elliot 1923 CPD 148

Stransham-Ford v Minister of Justice and Correctional Services [2015] ZAGPGHC 230

Shalabi and Another v Minister of Home Affairs and Others 2000 (3) SA 936 (CC)

Thomas and Another v Minister of Home Affairs and Others 2000 (8) BCLR 837 (CC)

The Government of the Republic of Namibia v LM 7 Others [2014] NASC 19

VRM v The Health Professions Council of South Africa 2004 20 SAJHR 309

Waring and Gillow v Sherbone 1904 TS 340

TABLE OF STATUTES

Constitution of the Republic of South Africa 1996

Choice of Termination of Pregnancy Act 92 of 1996

Child Care Act 75 of 1983

Children’s Act 38 of 2005

Mental Health Care Act 17 of 2002

National Health Act 63 of 2003

Sterilization Act 44 of 1998

BOOKS

Beaucamp TL, Childress JF *Principles of Biomedical Ethics* 7th Edition 2001 Oxford University Press

De Vos, Freedman W *South African Constitutional Law in Context* 2nd Edition 2021 Oxford University Press

Moodley K *Medical Ethics, Human Rights and the Law* 2nd Edition 2017 Van Schaik Publishers

Woolman S Bishop M *Constitutional Law of South Africa* 2nd Edition 2005 Juta & Co. Publishers

DISSERTATIONS

Ahmed R *Contributory Intent as a defence limiting or excluding delictual liability* 2011 University of South Africa

Barit A *Doctrine of Informed Consent in South African Medical Law* University of Pretoria

Chima S *An investigation of Informed Consent in clinical practice in South Africa* 2018 University of South Africa

Wilson MCI *Informed Consent to Medical Treatment: The basis of a claim and the standard of disclosure* 2008 University of the Free State

13 October 2021

Olivia Nompumelelo Bango –Rili 212531105
School of Law
Howard College Campus

Dear ON Bango-Rili

Protocol reference number: HSS/1406/018M
Project title: Consent Laws: Are a defence for Doctors or a positive right for patients : A critique of the post 1994 South African Legal Framework
Amended title: Consent to medical treatment: To what extent does the post 1994 South African Legal Framework on consent protect patients: A critical review

Approval Notification – Amendment Application

This letter serves to notify you that your application and request for an amendment received on 13 August 2021 has now been approved as follows:

- Change in title

Any alterations to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form; Title of the Project, Location of the Study must be reviewed and approved through an amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the discipline/department for a period of 5 years.

All research conducted during the COVID-19 period must adhere to the national and UKZN guidelines.

Best wishes for the successful completion of your research protocol.

Yours faithfully

……………………………………………………………
Professor Dipane Hlalele (Chair)

/dd
cc Supervisor: Professor Anne Strode
cc. Academic Leader Research: Dr Shannon Bosch
cc. School Administrator: Ms Robynne Louw/ Mr P Ramsewak